mental health digest

National Clearinghouse for Mental Health Information, Vol. 1, No. 1, January 1969

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cover story

The bars are coming down at Lexington. When the Federal hospital for narcotic addicts became part of the National Institute of Mental Health in 1967, plans were made to eliminate its prison-like aura.

A grim network of metal grilles throughout the Clinical Research Center and Addiction Research Center has been removed, and further remodeling is underway. A cell block where prisoners were isolated is being replaced with modern intensive medical care and laboratory areas.

There are fewer guards and their uniforms are less formal. The doctors have stopped wearing their Public Health Service uniforms. Patients are helping to govern themselves, using the grounds more freely, and enjoying fewer restrictions. (NIMH photo by Jerry Hecht.)

mental health digest

The *Mental Health Digest* is a monthly publication of the National Clearinghouse for Mental Health Information of the National Institute of Mental Health. Designed to reflect the whole spectrum of mental health and to present a broad sampling of subject matter and professional points of view, it contains condensations of journal articles, reviews, Federal and State program documents, and other pertinent material. It also contains brief mental health news digests, lists of publications available from the National Institute of Mental Health, and descriptions of other sources of mental health information.

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National Institute of Mental Health. Reprint of a 7-page article that appeared in *PHS World,* October 1967. Describes the Institute's program.

Narcotics. Some Questions and Answers. A 6-page leaflet. Discusses: narcotic drugs, narcotic addiction, the effect of the drug, narcotic users, the life of an addict, addiction-crime relationship, legal penalties, the medical view of addiction, the Narcotic Addict Rehabilitation Act, and efforts to learn more about addiction. PHS Publication No. 1827. 5¢ ($3.25 per 100).

LSD. Some Questions and Answers. A 7-page leaflet. Discusses: what LSD is, why people take it, its physical and psychological effects, its effect on thinking and creativity, how it acts, whether it is dangerous, whether it causes mental illness or birth defects, its special hazards for young users, its medical uses, how law views it, and NIMH activities concerning it. PHS Publication No. 1828. 5¢ ($3.25 per 100).

Marihuana. Some Questions and Answers. An 8-page leaflet. Discusses: marihuana, extent of its use in the U.S., its action, its physical effects, whether it affects judgement, the latest scientific findings, whether it is addicting, whether it leads to use of narcotics, laws dealing with marihuana, special risks for young users, why so little is known about the drug, and what research is being done. PHS Publication No. 1829. 5¢ ($3.75 per 100).

The Up and Down Drugs. Amphetamines and Barbiturates. A 7-page leaflet discusses: amphetamines, how they affect mood, their physical effects, how they work, their medical uses, whether they are misused, whether they are addicting, how dangerous they are; barbiturates and other sedatives, how widely they are used, their medical uses, their effects, whether their use is dangerous, whether they are addicting, legal controls, and research being done. PHS Publication No. 1830. 5¢ ($3.25 per 100).

Thinking About Drinking. A 30-page pamphlet for teenagers. PHS Publication No. 1683. 20¢ ($15 per 100).

The Medical School and the Community Mental Health Center. A 50-page report of a conference sponsored by the Southern Regional Education Board and the National Institute of Mental Health. PHS Publication No. 1858. 50¢.

Proceedings of the Third Annual Mental Health Institute 1967. A 32-page report of an Institute sponsored by the Prince George's County Mental Health Association, Prince George's County Mental Health Advisory Committee, Family Service of Prince George's County and the NIMH Mental Health Study Center on the topic "Mental Health Issues in Community Planning."

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Behavioral Genetics: An Overview

GERALD E. MCCLEARN

Merrill-Palmer Quarterly of Behavior and Development, 14 (1) :9–24, 1968

Simple Genetic Systems

The simplest system is one in which one gene has an effect upon a trait. A gene can exist in two or more forms, called alleles. Each individual has two of a given gene, one contributed by each parent. Different combinations of the alleles give different outcomes.

An example of a single gene having an influence upon a behavioral characteristic is phenylketonuria. The dominant allele may be symbolized by P; the recessive by p. PP and Pp individuals are in the normal range of intelligence, but pp individuals suffer from mental retardation.

Cytogenetics

The genes are located on thread-like bodies called chromosomes within the nucleus of body cells. Chromosomes occur as paired structures, one of each pair coming from the mother, the other from the father. The number of chromosomes is constant within an organism and within a species, but varies from species to species.

In the development of sperm and eggs, a mechanism guarantees that each egg or sperm will contain one of each pair of chromosomes. It occasionally happens that a mistake occurs, which results in a sperm or egg with both members of a pair, or no representative of a pair. The resulting organism will possess three instead of one pair (trisomy) or only one instead of two chromosomes (monosomy).

Trisomy of many of the chromosomes appears to be lethal. In some cases, the organism survives but is affected by abnormalities. One of these conditions is Down's syndrome. The chromosomes of man are classifiable according to size and other characteristics, and a standard nomenclature has been established. The chromosome identified as number 21 has been found to be present in triplicate in many cases of Down's syndrome, and the condition is known as trisomy 21.

In most cases, the individual members of the chromosome pairs appear to be equal, in the sense that each contains genetic information comparable to that contained on the other. In the case of sex chromosomes, however, this is not so. Females have two equivalent chromosomes, called the X chromosomes, while males have one X and a small Y chromosome. Much of the genetic material carried on the X chromosome is not represented by corresponding material on the Y. The Y chromosome in mammals contains male-determining genetic information of some kind. The distribution of sex chromosomes is usually quite precise, giving rise to XX daughters and XY sons. But mistakes may occur. A condition involving incomplete sexual development in ostensible males, Klinefelter's syndrome, involves two X chromosomes in addition to a Y chromosome. In addition to retarded sexual development, there are behavioral concomitants in a reduced intelligence level. A condition in ostensible females is Turner's syndrome, in which there are only 45 instead of the normal 46 (23 pairs) chromosomes. Only

an X chromosome is present. A specific type of cognitive defect appears to occur; Turner's syndrome patients are defective in spatial abilities, although verbal IQ measures fall within the normal range.

Quantitative Genetics

Rules governing transmission of genetic elements were worked out with reference to dichotomous qualitative traits. Efforts were then made to apply them to continuously varying, quantitatively distributed characteristics. The models assume that there are several genes that exert influence upon a trait, with the effect of any gene being relatively small. The effect of all the genes, working in concert, must be assessed by statistical measures. The system is sometimes described as a "multiple-factor" system, but a more frequent term is "polygenic." A related term is "pleiotrophy," which is used to describe situations in which a single gene has an effect upon several phenotypic characters; e.g., the albino gene in the mouse has behavioral effects in addition to the effect upon coat color.

A central concept is "heritability" —the extent to which the phenotype is a reliable guide to the genotype. Phenotype has been defined as that which is measured. Genotype is the genetic makeup respecting all the genes relevant to the particular character in question. A reason for lack of one- o-one correspondence between genotype and phenotype is the phenomenon of dominance, where different genotypes (one homozygous for the dominant allele, the other heterozygous) give rise to the same phenotype result. Another source of discrepancy between genotype and phenotype is effect of environment. A way of conceptualizing the genotypic value is to consider it to be the mean of the phenotypic values that would result if the given individual could be indefinitely replicated and reared under all environmental conditions to which the population is exposed.

Consideration of environmental sources of variance forms an integral part of quantitative genetics. During the nature-nurture controversy, the question was: Is a given trait due to heredity or environment? We now inquire as to the relative proportions of phenotypic variance attributable to genetic differences and the proportion due to differences in the environments.

Covariance among relatives of different degrees could be converted to statistical form which permits the estimation of heritability. Examination of such resemblances among relatives has indeed been widely used in human behavioral genetics. Parent-offspring correlation for intelligence tests is around 0.5, which is about the same as the correlation found for bodily dimensions, etc. Smaller correlations have been found for measures of personality. These values are complicated to interpret and one difficulty is in the confounding of genotype and environment; e.g., individuals who contribute alleles for superior intelligence to their children are likely to contribute environmental supports for intellectual attainment.

Another technique is that of studying twins. Identical (monozygotic or MZ) twins are identical genetically. Fraternal (dizygotic or DZ) twins differ genetically as much as do ordinary siblings. Differences between DZ twin pairs are attrib-

utable both to genetic and environmental sources. If we assume that the environmental variance component in MZ twins is the same as that for DZ twins, then by subtraction of the former from the latter we should obtain an index of the genetic variance source. One difficulty is the likelihood that fraternal twins are exposed to a wider array of environmental forces than are identical twins, and that the two environmental variances cannot be regarded as equal.

Studies of the resemblance of relatives in animals are possible and much less subject to the confounding of environmental and genetic variables that occur in man. The techniques most frequently used are not possible in human research. One is use of highly inbred strains. The mating of relatives in consecutive generations leads to a reduction in heterozygosity. If different inbred strains, reared in the same environment, exhibit different behavioral characteristics, these differences must be attributable to genetic differences between the strains. A comparison of inbred strains on a behavioral characteristic is a good indicator of the existence of genetic influence on a behavioral trait.

Such strain differences have been described with respect to learning ability, activity level, sexual behavior, alcohol preference, and aggressiveness.

Establishment of strain differences is only an indicator of genetic determination, and more detailed analysis requires comparison of means and variances of the inbred strains and of generations derived from them.

The other technique is selective breeding. Subjects with extreme manifestation of a trait are mated. In practical efforts—such as increase in milk production or egg size—this selective breeding is carried out in the desirable direction. In laboratory research, it is customary to breed in both directions.

Successful selective breeding has been accomplished for a variety of behavioral traits: learning in rats, activity in rats, aggressiveness in mice, geotaxis in fruit flies, mating speed in fruit flies, etc. Not only do these programs reveal that there was genetic contribution to the variability of the trait in the foundation population from which selection was begun, they also provide research animals with different values of the behavioral trait of interest.

Physiological and Biochemical Genetics

The chemical nature of the gene is quite clearly understood. The fundamental component is deoxyribonucleic acid (DNA). The molecule of DNA has a double helical structure. This may be visualized as two strands of phosphate and deoxyribose sugar groups wrapped around each other, but held a fixed distance apart by pairs of bases on the interior of the helix. Space limitations of the molecular structure are such that the four bases are paired in a certain way: adenine pairs with thymine; guanine pairs with cytosine. The doubled nature and the pairing restrictions give the capacity of self-duplication. This property is a requisite of the hereditary material, since the basic genetic information in the fertilized egg must be duplicated many times in the development of a multicellular organism. What appears to happen is that the two helices unwind, and each carries with it one base of each

base pair. The composition of the cell nucleus, in which this takes place, is rich in unattached bases. These attach themselves to the single bases that are in turn attached to the helix. The newly formed pairs are exact duplicates of the original. The process also involves duplication of the phosphate and deoxyribose sugar strands.

Information in the DNA molecule must be transmitted to the cytoplasm. This is accomplished by ribonucleic acid (RNA). By a process similar to that involved in DNA replication, an RNA molecule is transcribed on the DNA molecule, so that the sequences of bases in the DNA determine the sequence of bases in RNA. The RNA molecule goes into the cytoplasm, where it is involved in protein synthesis. The genetic "information" is coded by the sequence of bases and the code has been shown to consist of three-letter "words." Each succeeding triplet of bases specifies an amino acid, e.g., three uracils in a row (UUU) specifies phenylalanine; AUG (adenin, uracil, guanine) specifies glutamic acid. These amino acids join and ultimately form proteins. Of particular interest are the proteins that act as enzymes. These act as catalysts and are vital to the operation of the organism.

In research on animals, descendants of selectively bred "bright" and "dull" rats have been found to differ in brain levels of acetylcholinesterase and acetylcholine. These results, combined with data from other strains selectively bred for the level of enzyme activity, suggest that the ratio of these two substances is correlated with learning ability.

Developmental Genetics

Confusion sometimes arises between "hereditary" and "congenital." Consideration of the inheritance of adult traits that do not appear in the newborn should make clear that not all genes are "turned on" at birth or conception. In Huntington's Chorea, which is due to the presence of a dominant allele of the particular gene involved, the average age of onset is about 35 years. Other characters, such as blood groups, do seem fixed at birth. Still others, e.g., hemoglobin type, change systematically with age. Presumably, genes that are part of polygenic systems have differing times of onset.

The operon model of gene action has provided suggestions as to how genes may be "turned on" or "off" in developmental sequences. The model postulates different types of gene: regulator and structural. The latter is what we have been discussing as "genes." A structural gene has an "operator" adjacent to it, which is apparently the starting point for the molecular copying involved in transcribing RNA from DNA. A regulator gene, which need not be physically adjacent to operator or the structural gene, produces a repressor substance which attaches to the operator and prevents RNA transcription.

Behavioral geneticists have only begun to apply developmental genetic considerations to analyses of the development of behavioral patterns. Yet sufficient has been accomplished to indicate the promise of this approach.

The Legend of E.K. Reflections on the Nature of Sex

D. D. FEDERMAN

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Last fall the newspapers reported the case of E. K., an Olympic runner who was not allowed in races for women when she was shown to have "an extra chromosome." The story raised questions about the nature of sexual identity.

Normal Sexual Differentiation

Differentiation of the bipotential embryonic gonad is determined by the individual's chromosome constitution. In the presence of 2 X chromosomes without a Y, an ovary develops. When the sex chromosomes include a Y, a testis differentiates. Additional sex chromosomes may impair the function or limit the potential of this gonad, but the minimum control is vested in the second sex chromosome.

Development of the internal genitalia is controlled by the fetal testis. A double set of duct primordia exists in male and female embryos. In the presence of a functioning testis the Wolffian ducts develop into the vasa, seminal vesicles, and epididymes, while the Mullerian ducts regress. When the testis is defective or absent, and whether or not an ovary is present, the Mullerian ducts form the uterus, Fallopian tubes, and upper vagina, while the Wolffian primordia atrophy. Wolffian stimulation can be produced by androgen, but Mullerian suppression is achieved by a testis product which acts locally and is more like an embryonic organizer than a hormone.

The external genitalia develop from primordia that are sensitive to androgen and do not require the testicular inducer. In embryos of either genetic sex, exposure to androgen prior to the sixteenth week results in external virilization regardless of the nature of the internal genitalia. Masculinization is a positive event requiring positive stimulation; in the absence of virilizing substances, genital development is female regardless of chromosomal sex. Only the gonad, not the genitalia, is genetically determined.

Puberty is determined by the hormonal product of the gonad—estrogen and progesterone from the ovary or testosterone from the testis. Although the normal adrenal produces both small amounts of estrogen and larger amounts of weak androgens, neither will imprint an adult sexual identity in the absence of gonadal hormone.

The lifelong sexual designation of the newborn, made on the basis of a millisecond's observation of external genitalia, is possible because in normal infants there is concordance among the gonadal, ductal, and external genital findings. In abnormal circumstances, discrepancies occur which pose problems in assigning a gender role. The

recognition of additional criteria of sexual identity has been invaluable. The first was the Barr body, or nuclear chromatin, or nuclear sex—a clump of heterochromatic DNA visible in the nuclei of the cells of normal females but not in males. This test, the first marker of sex which showed no overlap between normal males and females, remains the most valuable screening procedure for the gonadal dysgeneses and the intersex syndromes.

The second approach was microscopic observation of the chromosomes of dividing cells. "Chromosomal sex" was shown in normals to parallel nuclear sex, the chromatin negative male having one X (and a Y), the chromatin positive female two X's. Although these two correlate with each other and with gonadal and genital sex in the normal, in abnormal sexual development all correspondences may break down.

The final aspects of sex identity are the psychological and social sex. Human and many animal societies prescribe behavior appropriate to each gender role. Assignment of gender is usually based on external genitalia, and the "psychological sex"—the individual's concept of his sexual identity—is derived from this "social sex," the way in which he is treated and expected to behave by the "significant others" in his environment. As biologically, so socially, the facets correspond in the normal but may at times be discrepant.

Disordered Development

In abnormal individuals the concordance breaks down erratically, and no single index can define the status of all individuals.

In Turner's syndrome, the internal and external genitalia and the psychosocial sex are female, but the gonad is neuter, the nuclear chromatin is either negative or positive, and the chromosomes can be XO or Xabnormal X. In Klinefelter's syndrome all anatomic criteria are male, but pubertal development is incomplete, the nuclear sex is positive, and the chromosomes may be XXY, XXYY, XXXY, etc. True hermaphrodites have both ovarian and testicular tissue; their internal duct structure is predominantly female, but externally most are male in appearance.

Congenital adrenal hyperplasia in females is an example of pure androgen excess. The patients are genetic females with ovaries and female internal genitalia. Their defect in cortisol biosynthesis results in increased secretion of androgen and virilization of the external genitalia. Such patients may live a male role indefinitely. Studies of such females-raised-as-males provide evidence that psychological sex was not genetically determined but was a result of the gender socially assigned in early experience. These studies indicated that this self concept was indelibly imprinted by 18 to 24 months of age, and could be undone thereafter only with risk of psychologic damage.

It was hoped that the newer objective criteria would be definitive. It was apparently those which subdued the aspirations of the Olympienne manquee, since she was, allegedly on the basis of a buccal smear, disqualified because of "an extra chromosome." But it is doubtful that such weight should be put on nuclear sex since a chromatin negative pattern can mean XO, XY, XYY, or mosaics of such

karyotypes, and the phenotype can range from Turner's syndrome to the normal male. Conversely, chromatin positive can mean XX, XXY, XXYY, and mosaics of same, and can indicate a normal female, a true hermaphrodite, or Klinefelter's syndrome.

Cytogenetic studies alone are similarly powerless, since 46/XX patterns indistinguishable from the normal female can be found in pure gonadal dysgenesis, true hermaphrodites, and a rare Klinefelter patient; 46/XY karyotypes are found in testicular feminization, ambiguously developed male pseudohermaphrodites, and chromatin negative Klinefelter's as well as normal males; and a recent hypothesis suggests that submicroscopic portions of a Y can be transferred to the X during male meiosis, producing a chromosome which is X^Y in effect although not visibly so.

The features of a normal sexual identity can be separated and recombined by disease. Recent progress makes it easier to interpret ambiguous findings and to rationalize treatment. But there are other spheres in which much more needs to be learned, and these include especially the psychosocial aspects. One group of patients are the "transsexual" in whom external plastic surgery and hormonal therapy have been used to convert individuals from one gender role and social sex to the other. Most often the change is male to female. From available reports these patients appear to represent a defect in the imprinting of psychological sex. By anatomic, endocrinologic, and cytologic criteria these males are males, but they do not think so. They assert that from their earliest awareness of sex identity they felt uncomfortable and mistaken as males.

It should be possible to reexamine other disorders of sexual identification such as transvestism and homosexuality, and to bring a new order of illumination to the lives of patients who have been too little understood too long.

Sexual Health and Family Planning

MARY S. CALDERONE

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Family Planning

From 1955–65, the most striking development in family planning was the emergence of the pill and the intrauterine device (IUD). People in general and professionals in particular were admitting the population problem.

Despite recognition of the problem, development of improved methods and acceptance by the American Public Health Association and the American Medical Association of family planning as a component of public health and medical practice, results are not as rapid as they should be. This needs examination. Epidemiology has taught us that there is a "critical mass" in disease control—control of disease is achieved when a certain minimal percentage of susceptibles has been

immunized. What is the "critical mass" for control of a population? This depends on many factors, of which perhaps the most conspicuous might be failure of individuals to be motivated for family planning. We have yet to beat our drums for birth control in the way we beat them for polio vaccine; we are unable to put babies in the category of dangerous epidemics, even though this is the truth.

We see evidence of other failures by individuals to take initiative and responsibility in various aspects of living, failures that have a wave reaction outwards into the community and nation. What is it that happens to an intact baby, that he comes to reproductive maturity emotionally immature, distorted, unable to recognize, elect, or carry out responsible patterns of sexual or other decision-making?

The factor most often mentioned is the lack of a sense of identity, and the reason most often given is the breakdown of the family, especially of the number of one-parent families.

Even as we stress the protective environment afforded by the two-parent family, we are forced to define what we mean. The two-parent nuclear family is a far cry from the extended family of other days or cultures. Each new nuclear family would appear to spring sui generis into spontaneous being, unconnected to previous family structure, and this lack of a connecting chain is most significant in the development of the individual child set adrift from any other family unit than his own. Here is the first break in the individual's identity development: the lack of a clear-cut connection backward, through continuing warm contact with mature individuals other than his parents, between the child and that moment in history in which he becomes part of the human scene.

Building a Sexual Identity

I have spoken of the child without assigning a gender, a state that exists until the moment of birth, at which moment the infant is sexually undifferentiated except as to anatomy. This anatomy leads us to assign it to one sex, and at this moment the process of sexualization is begun by the mother. She begins to build a sexual identity by her attitudes and expectations of role and behavior as male or female. Here is where the second break can come in the development of identity, depending upon the cultural milieu in which the child and his family have their being.

What does all this have to do with sexual health and family planning? The point is: the sweep of time has served to trap human beings in massive herds at the moment when technology has the capacity to free them as never before to fullfill their highest potential. We see the spectacle of a society that denies the unique and precious value of each individual, to himself or to his society, by the very way in which these individuals of every social class are forced to live under depersonalizing and dehumanizing conditions. I would postulate that man is not a herd animal. But for his fullest evolution as an individual the human being requires a minimum of space, sky, earth to touch, a mother and father or their effective surrogates to care deeply about and for him, and time—time to be alone, to think, to dream, and most especially time to evolve each individual from infancy on-

ward at his own particular rate. The pattern of society is such that rich or poor seldom have these things—the rich because they have been brainwashed to value possessions above all else, the poor because they cannot help themselves.

The child must be recognized as the vulnerable Achilles heel of our society. Generations are swarming up which will be incapable of relating to other human beings. The child is the target of many unseen, unverbalized, contradictory forces: the communications media hold up the image of a precocious little man or woman, toilet trained, dressed in sophisticated adult fashion, playing sophisticated adult games, pushed to read, perform, mimic adult life in dancing or singing or acting, to mature as prematurely as possible, with early dating and socialization the norm.

These forces do not always act through the medium of an ambitious middle-class mother. They operate through the television set in the tenement around which children will be grouped for hours absorbing its inanities as the only truths they know. What other resources do they have to balance its impact? The violence and depravities of the life they see at first hand? The inadequately staffed and equipped public school? The period between birth and 10 years is the critical period when many aspects of the child's nature must develop: cognition—ability to think, reason, acquire and apply factual knowledge, deal in abstract terms; affection—ability to relate warmly and supportively to others on a two-way basis; and in particular, sexualization—development of the individual's sense of identity as male or female in preparation for the coming man or woman.

Sexual Maturation

We have tended to equate reproductive maturation with sexual maturation. There are three processes involved: reproductive maturation appears autonomously and automatically at puberty in male and female. The process of genitalization—the ability to localize genital sensation into the experience known as orgasm—in most males is accomplished autonomously and automatically in the form of nocturnal emissions, if it has not been developed by masturbation. The process in girls is less clear cut, more erratic, subject to happenstance and external influence: infant girls may masturbate to orgasm and continue throughout childhood and into maturity. Others may not learn orgasm until later, or may have learned and suppressed it; the genitalization process is more likely to be self-learned or learned by seduction. We must question whether the differences between the genitalization in girls and boys are inborn or are culturally derived; the tendency is to hypothesize the latter.

This leads us to the question of the development of the personality structure of the individual as male or female, and the relationship of the other processes, particularly the process of genitalization. What is the effect of the eroticism in our society impinging on the young of all ages on the sexualization process? In trying to accelerate growing up, what do we do to the step-wise process by which the individual builds his self identity as male or female? Can this process be compressed, elided, without distortion?

Can genitalization be precociously stimulated, or heterosexual expression experienced earlier and earlier, without being at the expense of the more long-term, subtle, and profound process of sexualization?

Sex Education as Preventive Medicine

What happens to the young male or female who is reproductively mature and, as a result of social processes, genitally potent, but who is immature in sexual and personal identity, who is given freedom to come and go in a social life developed outside of whatever family he has—and in the face of all these things has made clear to him by society that he is of no use to anyone, he cannot contribute effectively, he is still a school child, not entitled to be given sound information about his own maturation processes and the feelings that they engender—and that above all, he is under no circumstances to permit himself to respond in any way at all to the welter of erotic stimuli that assail him on every hand?

Is it any wonder that young people denounce the adult world for its two-faced cowardice? We use sex as a commercial expedient, while we refuse to answer questions about a life process we all have, that is fundamental to our well-being, an integral part of our inmost selves, underlies our most important social structure, gives us our most powerfully experienced moments of being alive.

If we can get away from the stereotype that sex education has primarily to do with reproduction, intercourse, venereal disease prevention, or illegitimacy rates—and can broaden our concepts to encompass the total process of sexualization, then public health workers may understand the role they have to play in sex education as preventive medicine. This role will be played out on two levels—the organization and the individual.

Public health workers should recognize that many of their activities relate to this fundamental aspect of man's being: well baby clinics where the mother receives teaching and guidance in the growth and development of her infant and young child; family planning and venereal disease clinics; mental health centers; school health programs—in all of these the relevance of the attitudes and knowledge of the public health worker about human sexuality is obvious. There are many less obvious relationships, e.g., sex attitudes can interfere with breast and vaginal examination.

When we deal with individuals on behalf of organizations, our helpfulness may be limited by the posture of the organization itself. This was true for many years with regard to family planning services. An example is the question of whether a mentally handicapped person should be denied a full sexual life. If we accept the responsibility of caring for and about mental retardates, then why should we not be willing to accept the responsibility of according them access to the warmth of a permanent marriage relationship, sheltered in honest and medically ethical fashion by a sterilization procedure? This topic is shunned, and retarded children are open to sexual exploitation or deprivation and their parents flounder and agonize on their behalf.

Organizations are made up of individuals, and, as happened regarding contraception, the attitudes

of individuals must shape the attitudes of institutions. How can the worker in any one of the public health fields orient himself regarding the concepts emerging about sexuality and the role these concepts play in his work?

The first point is the interdisciplinary implication of this field; all the medical and paramedical specialties are involved. The teaching professions are involved, not only in the transmission of factual knowledge in biology, health, or physical education classes, but in the more subtle transmission of attitudes and values in literature, history, the social sciences, and in the confrontation of the profound sex-related issues of our times in current events. The major religions have been taking steps in the consideration of human sexuality and education about it.

Recognition of the personal stake for every individual is inevitable. We are born as sexual beings and remain so. We have sexual feelings, sexual relationships, and not one of us can move through life without at some time having a sex-related problem. It is our individual responsibility to prepare ourselves to be of help to those individuals whom we will meet professionally, recognizing that we will be contributing not only to the welfare of society, but to our personal welfare and understanding.

I believe we are going to discover many interconnecting links and pathways that relate to personal identity, human relations, child development, adolescence, mental health, family planning. The question of race relations ties in with the problem of identity, particularly in the Negro male, which keys in to the question of sexual identity and changing male and female roles in marriage and the entire society. Cultural patterns are determinants of the kinds of men and women that children will become, and in the kinds of communication with each other that men and women are able to establish.

We are forced by inexorable logic to focus on the sexualization process and how we might learn to free it from its cultural straight jacket—in order to do it better so as to produce men and women who are freer in being and acting *as* men and women, more responsible in their reproductivity, but more importantly, in their concern and love for each other as men and women. We must engage in education for sexuality, for sexual fulfillment, for sexual responsibility, for sexual health.

The Church and the Homosexual

Rev. Morton T. Kelsey
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What is homosexuality? It is the sexual desire on the part of one individual for a member of the same sex. It has deep unconscious roots and takes heroic strength to control. This desire can be expressed in action and bodily contact. There are as many variations of physical gratification of the homosexual urge as there are of

heterosexual desire. The homosexual act may, like the heterosexual act, be the result of mutual consent and affection, or it may be the result of seduction, violence, or compulsion. Homosexuality contains the full repertoire of sexual expression. Because of popular and legal condemnation, only the less savory aspects of the subject usually come to the public eye.

The law expresses this social horror. Sentences ranging from fines to life imprisonment are on the statute books of the American States for the punishment of one homosexual act.

The object of the homosexual's affection may vary from an adult of the same age to an older adult or a child. This sexual expression may take place in a casual encounter or may be one aspect of a relationship characterized by commitment, affection, devotion. The popular approach that sees no distinctions is one of several value judgments of homosexuality. It involves the view that these individuals perversely desire to be homosexual and to defy social conventions. Along with this attitude goes the belief that they must be changed, and only through punishment can they change. This attitude is the basis of most of the statutes in this country. I have yet to find one homosexual whose basic pattern was changed by legal punishment; imprisonment places the individual in a situation that is more favorable to homosexuality.

Another judgment, accepted by many, is that homosexuality is a physical, glandular, or psychic predisposition. If this is true, then there is little point to punishing homosexuals.

In psychoanalytic theory homosexuality is seen as one stage in the development of full heterosexuality. The individual is drawn first to the same sex because he relates to the known more easily than to the unknown. Homosexuality is a sickness in that it is a fixation at an immature stage of development, although this is using the term "sickness" in a loose way. According to depth psychology, this personality variation is difficult to change, as it necessitates the change of one's essential identification with his psychic role.

Still another psychiatric viewpoint is that homosexuality may have many different kinds of causes, and each individual case needs to be studied and interpreted on its own merits.

Finally, there is a segment of the homosexual society that expresses its views in which the homosexual adaptation is viewed as superior to the heterosexual—a final, crowning mutation.

In this sketchy survey, we have left one question: Is homosexuality a sickness? Certainly it is not a physical disability, and psychologically there does not seem to be any direct connection with mental illness. Homosexuals are subject to more sexual tension than are heterosexuals, in part because they are placed in so many situations that can only be compared to settling a heterosexual male down in a dormitory of chorus girls. There are sick heterosexuals and sick homosexuals. These latter have little control of their sexual impulses, and certainly they are more likely to express them in an antisocial way.

Why is there such horror of homosexuality today? What is denied expression tends to become

overvalued, and to be feared inordinately. In societies where there is no attempt to repress homosexual activity, studies show that most young males pass through to a heterosexual adjustment, very few remaining homosexual. Many societies provide initiation rites to help make this transition from the feminine identification to a masculine one, while our society offers almost no help in this area.

Christianity has a different attitude toward sickness and most aberrant behavior from that of many religious groups. Christians understood sickness of mind and body to be the result of some evil force in the universe, the destructive, the uncreative breaking out in man. Their task was to bring him the healing available through the Holy Spirit and God and medicine. There was no judgment upon the sick.

If homosexuality be a psychic illness, then the importance of acceptance and concern is even greater. The same is true if homosexuality is a fixation at a lower level of maturity. The attitude of rejection is common in most churches and in most of society, and so both groups reinforce this problem, if it is indeed a sickness.

If homosexuality is not a sickness but an anomaly of nature, the attitude of Western society and the church is cruel indeed. The homosexual is judged on account of his feelings for which he is no more responsible than for the color of his hair. Or, if it is only his action that is objectionable, is it possible to deny him an expression that is so large a part of other people's lives, simply because his constitution is such that homosexuality is his way of expressing his sexual desire?

If homosexuality is a variant type of personality, it is hardly a moral question if it is not exercised with force, or upon those who have no right to consent, or in the open violation of public decency, rules that apply to heterosexual acts as well. In these circumstances it would seem that the task of the church and society is to offer the homosexual understanding and help to change his pattern, or to come to control, sublimation, abstinence, or a meaningful relationship, as individual circumstances dictate. He would be encouraged and helped not to use sex as an avoidance of relationship, but as a part of an abiding and meaningful one. And this brings us to the matter of relationship and love.

Christianity has always placed a high value upon human relationship. The experience of caring for others, of love, of *agape* (the Greek word for the most complete form of love) is that which gives men genuine access to the realm of the spirit. This is not accomplished by thinking or acting logically, but by something quite different.

In our time it is again possible to realize that when a man and woman have come to a deep and abiding relationship of love in which physically, emotionally, and spiritually their lives are blended into a harmony of closeness and yet distinction, there is expressed in reality that mystical union which is between Christ and the church. Most modern churches romanticize marriage but fail to see what it can be in honesty and reality. There are homosexuals, as well as heterosexuals, who have experienced this breakthrough and spoken of it in our own time. We may not like to face these facts, but in spite of the

condemnation of the Christian church, they appear to be the religious facts.

As one studies homosexuality objectively and impassionately, it is difficult to come up with the negative reaction to it that is found in the popular mind. It is true that there are outer manifestations among certain rebellious and "sick" homosexuals that give rise quite understandably to these prejudices, but they are not an adequate sample of the homosexual population, nor do they represent the essential quality of the manifestation.

What should be the attitude of the church toward homosexuality? There are three areas of action to consider—educational, legal, and pastoral.

The church should work with interested groups in which individuals may be permitted to speak freely for the enlightenment of prejudices.

In addition, the church needs to provide guidance to families as to how to help the young man make the shift into male identification. Whether some modern initiation rites are needed, or whether better family education on the nature of psychosexual growth or some other method would be best, some kind of education needs to be provided in this area. The young man who is trying to find his way often finds a place to talk about his problems only in the homosexual society. The church ought to provide a place where the confused youth can discuss with openness his fears and doubts and aspirations, without censure or prejudice.

The church should work for the repeal of the present unrealistic laws against homosexuality. If the homosexual by his actions is willfully causing damage to society, then it is up to the law to define such cases. But if the homosexuality is a matter of private morals, it should not be punished by the law. And if it is a sickness or simply a variation, then the laws are absurd.

Finally, in the pastoral ministry the church should treat each homosexual as an individual. Nothing is more important in a matter so rife with prejudice than remembering the Gospel injunction, "Judge not lest you be judged."

If the church understands the rebellion and rejection of the homosexual, it can provide the best counseling situation for the individual who needs to gain more control of his impulses, or needs psychological help quite apart from his homosexual problem. As long as the State maintains legal sanctions against homosexuality, it will be difficult for the sophisticated homosexual to turn to State agencies for counseling and help, and private counseling is beyond the means of many people.

The church should provide spiritual direction and welcome for the homosexual who finds that he cannot or does not want to change his sexual orientation. There is no group in our society, with the exception of the Negro in the South, who is any more rejected and cut off from normal social life. The homosexual needs and is capable of knowing and serving God as much as any individual, and the church needs to provide him with the fellowship, sacramental life, and pastoral care that it tries to offer other human beings. And who knows what creative possibilities may lie in its attempt to carry out these actions?

Mental Health and the Schools

Schools Are Our Community Mental Health Centers

STONEWALL B. STICKNEY

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Studies have shown that we reach at best 5 percent of our emotionally disturbed children. It may be that the schools are the best place to treat, as well as teach, nearly all emotionally disturbed children.

Custodial Role of the School

The consideration needed to complete the argument that schools are mental health centers is obvious—the compulsory attendance law.

Only immersion in the psychosis, suicide attempts, antisocial behavior, and chaos in our schools could convince the mental health professional of the community mental health mission our teachers are expected to perform. Schools accept children who would find few places in child-shelter institutions; they would be considered too "sick" or "aggressive."

The School as Casefinding Agency

Because of the attendance law, the school has become the only effective casefinding agency, and it may be the ideal casefinding agency for disturbed adults with school-age children.

The services described in the literature on comprehensive mental health planning are being performed by many schools. Federal and State funds earmarked to support such services should also go to school mental health programs and not be squandered in trying to approximate such services by reinventing them in a new community mental health center.

Schools have been placed by law and circumstances in the position of having to take care of most of the emotionally disturbed children. But the schools have been granted no special facilities nor have teachers been prepared for such a responsibility, nor have public funds been forthcoming to ensure facilities and training of teachers. A school mental health program must find funds to train teachers and administrators for their mandated mental health function; find mental health consultants to carry out the training; and find the space, specially trained teachers, materials, and methods to contain, teach, and help the emotionally disturbed children within the school system.

The mental health consultant must be prepared and available to provide crisis consultation service, in addition to inservice training and screening and supportive visits to schools having the special containment "spaces," i.e., classes for emotionally disturbed children. Without inservice training of teachers, a school mental health program will be so busy with crises that no prevention program can develop. The same reasoning applies to classes for emotionally disturbed children. "Clinical diagnosis" does not seem to offer much help, yet this is what has often been offered by mental

health teams in school systems.

The psychiatric consultant is a resource too scarce to be spent on clinical diagnosis and direct interaction with students or parents. He must multiply himself by training everybody he can, mainly teachers, to be both casework informants and therapeutic aids.

The Pittsburgh Program

In 1965 the Maurice Falk Medical Foundation gave the Pittsburgh public school system a three-year grant for a school mental health program. In the first year our staff consisted of a coordinator, psychiatric consultant, and director on half-time. The second-year staff included the coordinator and consultant full-time, another psychiatric consultant half-time, three social workers, a secretary, a research associate, and a clerk. The staff also included 12 teachers and aides to work with emotionally disturbed children.

The first year could be described as the phase of hazing into the school's complex subculture. In getting acquainted with principals, teachers, home and school visitors, psychologists, and counselors, we were developing and refining a method of consultation.

All referrals are relayed to us via the principal. We learned that without the informed consent of the principal any diagnosis or treatment plan would be irrelevant and ineffectual. We learned that the school social worker must be informed of, and consent to, the referral. By the time a referral reached our coordinator, it was a joint referral no matter who had originated it.

When we arrived at a school the principal made available teachers who knew or had taught the child to be discussed. Each consultation was teacher-centered, with primary interest and credence granted to the teacher's firsthand observations of the student and his family. The focus shifted to the account of the home visit by the school social worker, with data on birth, health, family history, etc. Data were then elicited from the psychologist.

The consultant would then depart from the passive psychiatric stance and say, "I think all this adds up to such and such difficulties in the home, school, or behavior of the child. And I think we should try this with his family, that with his schedule, and arrange time for Mr. X to work with him on these difficulties." The most important part came when the consultant said, "I'll be back next week to see if anything we decided today made sense. If it didn't we'll revise our plan."

These statements are the hallmarks of a good consultant. He hears everyone out who knows the child, makes his best clinical guess about the sources of difficulty, states a plan, and assures his informants that he will be back to revise whatever was erroneous. Educators can perform a service to psychiatry in gently, but firmly, insisting to each new consultant that he is not to leave the building until he has met all three requirements. School consultants must be trained on the job. Their psychiatric residency and clinical experience do not prepare them for the complexities of school consultation.

While listening to the faculty describe the child, the consultant is alert to several questions. "Who shall help the child?" If the child has found anyone to depend on or confide in, from the custodian to

the principal, this choice is honored. The psychiatric and social work consultants become supporters of, and consultants to, the elected adult, who will be the primary therapeutic link with the child. A similar approach is used toward the parents. If nobody has been elected, the consultant helps the group choose the best person. There are many parents and children who will confide in a teacher but will not go near a counselor, social worker, psychologist, or least of all a psychiatrist.

If the consultant has survived the crisis consultation, he has time and opportunity to provide inservice training for teachers by weekly case seminars. The consultant meets with 10 or 12 teachers to discuss particular children they are concerned about. This criterion, "concern," is sufficient. If the teacher sees enough distress in the child or parents to feel concern, this is sufficient cause to discuss the child.

The learning in these seminars is slow, intense, and as much visceral as intellectual. Texts, poems, plays, and rarely, case histories are introduced only as called for. Psychiatric labels and other nonsense of a generalizing and mystifying sort are avoided.

The hope is that teachers can become more informed, purposeful, and effective therapeutic agents with children. Their therapeutic function has always been inseparable from their didactic role, so it is not a question whether or not teachers will perform therapeutically. The goal is that learning—emotional, scholastic, or social—will be fostered and strengthened in a school that becomes a therapeutic community.

For the more seriously disturbed children we must construct small therapeutic milieus inside, and freely communicating with, the larger school environment. These have been described as special containment spaces because their first purpose is to contain those children whose behavior is uncontainable in regular classes. This criterion screens in mostly the clamorous, aggressive, or openly bizarre children. A later development is referrals for behavior that is depressive or withdrawn.

We do not attempt to change this sequence, having learned that whatever we do must be felt by principal and faculty to be practical, helpful, and fitting their needs. Most teachers learn to be as concerned about withdrawn children as they are about others. Once a school has been relieved of its most difficult burdens, it has more patience and time to devote to individuals.

Children are not stored in these special classes. They are filtered through them at a rate commensurate with their needs and conducive to their early reintegration into regular classes. The teachers have been selected because they are good teachers first, and have shown talent in dealing with difficult children. The teacher likes children, is affectionate and humorous but firm and consistent, and is relatively shockproof and nonpunitive. To these qualities we add special training and regular consultative support, but these additions are not intended to transform teachers into psychotherapists.

Our special teachers are instructed to approach students coming into the program by offering help with school subjects. Almost always the disturbed child is also having learning difficulties, so that the

offer is not seen as inappropriate or threatening. He learns that this teacher has the time, patience, and skill to help him with emotional and social as well as academic learning. Many children, especially adolescents, will accept help from a teacher but from no one else. We have learned not to retain a troubled child in school when that child is trying, consciously or unconsciously, to be expelled so that he can be removed from an untenable home situation.

The Ecological System of Diagnosis

The dilemma of the child who needs to be expelled brings up another issue, the philosophy of psychiatric diagnosis. With these "squeezeout" children, the relevance of the child's diagnosis diminishes in proportion as the pathology of the family and of the school increase. The only practical model becomes an ecological system in which the intrapsychic factors are noted but are only a part of the complex total diagnosis. It must include a description of the two ecological niches, home and school, in which the child must establish himself and grow. If he is in danger of being excluded from either, the child's condition is serious, regardless of his clinical diagnosis. On the contrary, a child with psychosis, brain damage or other serious clinical diagnosis may have a benign condition if home and school are receiving and containing him, and fostering his growth. It is apparent that our biggest diagnostic hiatus is in the area of learning impairments, be they emotional, social, perceptual-motor, or whatever.

We are beginning to meet this need by providing diagnostic screening for all exceptionalities (including talents and strengths) in all children in special and "readiness" classes. When we have funds, we plan to screen all children before they enter first grade. This will be our first truly preventive effort of a sort that can be demonstrated, tested, and found effective or ineffective within a few years. If we succeed in reducing only the incidence of school "failure," we might show that this one change could lower appreciably the numbers who decline rapidly—from failing, to dropping out, to delinquency, and to various severe social-personal patterns of failure and illness.

The final phase of our program is collaboration with schools of education in training teachers. Most new teachers are not prepared to deal with classroom management, much less to deal with disturbed children and families. Our hope is that we can devise training methods that will prepare teachers for life in our schools.

The School as Coordinator of Community Services

There is much to be done while the school mental health program is working toward long-term goals. The uncoordinated nature of interagency collaboration with referrals, re-referrals and reevaluations of children may have a chance for resolution. Every time a conference is held concerning a child who is known to a community agency or who may become involved with such services, all relevant agencies are invited to send a delegate to the conference. The delegates do participate, and often we arrive in one session at a general agreement that usually requires

weeks or months via the ordinary modes of communication.

The school seems to be a natural, neutral, even friendly ground for all interested parties to meet upon in a mutual effort to help a troubled child. We hope to demonstrate by such collaboration and by school-centered methods of child, teacher, and family reeducation that our schools are indeed our natural community mental health centers.

The Principal is Often Overlooked

MARSHALL SHEARER
Community Mental Health, 4 (1) :47–52, 1968

The psychiatrist serving as consultant to a school often finds himself called upon to understand the school organization as well as the child. While a request for psychiatric help is frequently made by a visiting teacher (a teacher-social worker) or school diagnostician, the request is made with the awareness and approval of the principal who carries primary responsibility for the morale and smooth functioning of his school.

The principal is less likely to become involved with the withdrawn child, but the class funny boy, the acting-outer , the scapegoat, or reject he knows well. He requires no assistance with most cases, but when referral is made, the nature and extent of the involvement can be crucial information to proper handling of the child's difficulties. If the involvement has been more than superficial, the psychiatrist should be alert for transference and countertransference problems.

The visiting teacher often is aware of subjective, interactional factors in the child's school situation. Even though she serves several schools, she is dependent on the principal and works closely with him. She may hesitate to pass along information which may put the principal in a bad light, particularly when she does not know the consultant well.

One visiting teacher tried to compromise during an evaluation by saying, "He is a potential dropout." After several questions, it was learned that the principal was going to "allow" a boy to drop out. "Allow" was then understood to mean "encourage." Without a psychiatrist's statement that nonattendance was in the best interest of the boy, the school board required that the school make every effort to prevent his dropping out. The principal's motivation was to obtain such a statement. The principal was caught in a transference-countertransference problem; the visiting teacher was caught in a dilemma; the psychiatrist was almost caught in the dark.

Principals should not be expected to understand the transference phenomenon. They use their personalities readily and freely (as they should) in dealing with pupils. The visiting teacher usually knows the techniques the principals use with behavior problems. She will also have information about the pupil's teacher, classmates, siblings, and community. A case history shows the importance of a talk

with the visiting teacher before evaluating the child.

The coordinator of special services received a call requesting the psychiatrist to see the "worst boy in the school." The visiting teacher had not previously been involved. The consultant arranged to meet the visiting teacher, feeling that it would be educational for her to sit in on the interview. An opportunity to talk with her beforehand was not arranged. The consultant interviewed the boy, his divorced mother, two teachers, and the principal. The principal presented the boy as a lying, stealing, calloused, dangerous culprit. The boy had low self-esteem and poor masculine identity. He was bolstering it by fighting, being the class funny boy, and placing himself above the teachers. Although the boy had been disruptive in class and attracted attention, he had never been referred for visiting teacher service. The visiting teacher knew his friends, who were mischievous and dare-devilish, but would respond to firm controls, warmly applied. The boy's teachers were surprised that the consultant had been asked to see this boy. Only after seeing these attitudes did the principal modify his insistence that the boy be sent to an institution.

Not only did the visiting teacher know the boy's group, but she knew that the boy had been considered the "principal's pet." She knew that initially the principal tended to be warm and fatherly, but when his approach didn't produce results, he would adopt a "Dutch uncle" approach. This case illustrates an important consideration—narcissistic injury to the principal. Some children test the principal's affection by making demands upon the relationship; others try to see how far they can go and still maintain the relationship. The principal may become frightened at the "sticky involvement" or suffer a blow to his self-esteem when a boy acts out. If no one can "do anything" with the boy, the principal escapes narcissistic injury.

The following are the hallmarks of this situation: Absence of referral to the visiting teacher in the face of a chronic problem; an urgent request for psychiatric help out of channels; sudden explosion in a chronic problem; use of the expression, "worst boy in school" or other negative superlatives; lack of concern by the classroom teacher (s) ; principal's desire that the boy be placed outside his principalship.

Once this situation is recognized, one should indicate that the extent and severity of the problem is recognized and appreciated. An "out" should be given the principal. This is readily done when the principal's approach has been therapeutic, but the improvement he expected was unrealistic. The consultant may point out deterioration in the home situation which the principal may not be aware of, or acknowledge the demands placed upon him by the child which realistically no one could have met.

The involvement of the principal is usually beneficial and may be necessary. In some cases, the visiting teacher may not see the child but may serve as a sounding board for the principal or keep him posted on developments in the child's home.

Many children, especially those without fathers, get into minor difficulty in order to be sent to the principal. Other opportunities for boys to foster a relationship with

the principal should be available. A boy should not need to misbehave to get kind words. If demands for acceptance or approval become excessive, they cannot be met and the child will feel rejected. Unless this is pointed out to the child, it will result in the child's feeling justified in his resentment and hatred. The principal and teacher may feel guilty for not meeting his demands; this may lead to overindulgence and the cycle will repeat itself.

There are cases in which the motive for the referral for evaluation is the need for reassurance on the part of the principal or teacher. Most often they have been overoptimistic. They are usually conscientious, intuitive, and capable. If they are given license to do what they intuitively feel needs to be done, things will go quite well. This function of reassuring school personnel that they are doing a good job has perhaps the largest mental health impact of any function the psychiatric consultant can perform.

The principal is the first person the classroom teacher turns to for help with a pupil's problems, and no child under his aegis is referred for help with emotional problems without his awareness and approval. An understanding of the general nature and extent of the principal's involvement may be crucial to the success of any therapeutic program suggested by the psychiatric consultant.

What is the Role of the Elementary School Teacher

ROGER F. AUBREY
Elementary School Journal, 68 (6) :277–283, 1968

There are four major conceptions of the role of the elementary-school teacher: a general coordinator of instruction; a combination guidance-teacher person; a strong disciplinarian and molder of moral values, a task-master and a model that pupils can use in their own patterns of growth; a subject-matter expert.

In practice, the four roles are not separate and distinct. Three, however, seem inappropriate and unrealistic. The first is the role of the teacher as a coordinator of instructional resources. Part of the rationale for this role is the knowledge explosion. No teacher can be prepared to encompass and teach what is constantly changing and being added to. The teacher is expected to be a master librarian of knowledge, dispensing it according to the pupils' needs and desires. Advocates stress team teaching, ungraded systems, and resource centers as solutions to the problem.

This position is an outgrowth of the technological revolution. The effect on teacher and pupil remains to be seen. In ignoring the personal dimension it is assumed that intellectual stimulation alone is incentive enough for teacher and pupil. This scheme has little or no place for motivation, desire, and interpersonal relationships, unless they are included under the broader and more valued objectives of instruction.

Teachers have difficulty resisting the role of the mental health ex-

pert because of its emphasis on social-emotional development. Many teachers and administrators accepted these responsibilities without considering the consequences. More amazing than the schools' acceptance of many of the responsibilities of the family and the community is the notion that the schools initiated and desired this shift of responsibilities.

Can the teacher fill this role? Since many assume that the teacher has been filling this role, it may be foolish to question this stance. But the teacher lacks training and the experience to qualify for a counseling role. Granted that the teacher deals with some behavioral manifestations that a counselor would treat, the teacher is still inadequate as a counselor. Her sophistication and expertise lie in another direction. Teachers trained in science should not be required to teach English; a teacher trained in a subject should not be expected to deal with emotional problems. She is untrained in determining causes and managing treatment. Teachers may do more harm than good if they are asked to function as counselors or junior grade psychologists.

What if a teacher has personal and professional qualifications that make her adequate in the guidance role? Can the teacher serve as a counselor and function effectively as a teacher? I believe not.

The teacher functions from a position of power and authority. The establishment of a new and different type of relationship—a relationship other than that between teacher and pupil—is necessary for counseling. A counseling relationship calls for a meeting of equals, for mutual understanding and acceptance. It is highly improbable that even the best of teacher-counselors could fill the two roles for long. One role would deteriorate at the expense of the other.

The fact that the traditional role has singleness of purpose is in its favor. It has an occupational and personal identity that is lacking but desired by today's elementary school teacher.

The traditional role died a slow death. The progressive movement, constant expansion of knowledge and curriculum, pressures on schools for more help with mental health, departmentalization, larger schools, urbanization, and a host of other factors, led to a gradual disenchantment with the traditional role. The teachers themselves have resisted this role as they have received better training in subject matter instead of methodology. They have had better preparation as imparters of knowledge than as moral models and disciplinarians.

The suggestion that the role of the teacher is best served in her capacity as a subject-matter specialist does not mean that the teacher will not assume the other three roles from time to time. However, the teacher will use the role of subject-matter specialist as her main frame of reference. When there is a conflict in roles, the teacher's primary role will be clear and may be used as a measure for judging her possible effectiveness in other teacher roles.

If the schools want discipline, they should hire deans or administrative aides. If they want needs of disturbed children taken care of, they should hire psychologists and counselors. This principle holds for all the other roles thrust upon elementary school teachers today.

Behavior Therapy with Children: A Review and Evaluation of Research Methodology

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Psychological Bulletin, 69 (3) :204–215, 1968

Children have become a popular client population for behavioristically oriented therapists. Reasons may be the brevity of the treatment, relative ease with which children's social environments can be controlled, and types of maladaptive behaviors for which children are referred for treatment.

An element of behavioristic treatment interventions is manipulation of the client's environment so that undesirable behavior patterns are eliminated and prosocial responses are reinforced. Environmental control is often easier to achieve for children than for noninstitutionalized adults. Since the child spends the major part of his time among his family or at school, the therapist can manipulate his social experiences by instructing a small group of people, the teacher and parents.

Children are often referred for maladaptive behaviors that are among the most amenable to behavior therapy techniques. The complaint is a well-defined behavior such as bedwetting, a phobia, or temper tantrums. It has also been suggested that the type of specific and detailed instructions parents receive from behavior therapists more nearly meet the parents' expectations than do the more general and vague directions traditionally given by children's therapists.

As a consequence, parents may be more likely to aid with the therapeutic effort. Parental sabotage is thought to occur in traditional play-therapy interventions, and it is not uncommon to hear a therapist state that the parents do not want their child's adjustment to improve. The same charge has not been made with any frequency by behavioristically oriented therapists.

As used here, the term "behavior therapy" refers to treatment techniques derived from theories of learning and aimed at the direct modification of one or more problem behaviors rather than at affecting more general and less observable personality or adjustment changes. Because behavior therapists assume that both desirable and deviant social responses are learned, their treatment interventions consist of laboratory-derived learning procedures, e.g., modeling and operant and classical conditioning.

Behavior therapy studies can be classified in terms of the desired effect on rates of children's emission of both undesirable and prosocial behaviors. Some treatment interventions aim to decrease the production of problem behaviors, others attempt to enhance the variety and likelihood of occurrence of desirable responses such as adequate language and motor skills, while a third approach combines acceleration of rates of prosocial behaviors with elimination of problem behaviors.

Deceleration of Maladaptive Behaviors

Phobias—A large group of therapeutic interventions aim to decrease the magnitude and frequency of a variety of problem be-

haviors. The technique involves pairing relaxation and enjoyment with anxiety-evoking stimuli so the previously fear-provoking stimuli become associated with pleasurable feelings. An anxiety hierarchy is constructed with items ranging from least to most fear-provoking situations, and the child is helped to imagine progressively stronger fear items under uninterrupted relaxation. This technique has been used to combat irrational fear of water, fear of hospitals and ambulances, school phobia, and dog phobia.

Antisocial and immature behavior—Behavior therapists have reported success in the treatment of aggressive, antisocial, and immature behaviors. Periods of time out from positive reinforcement have been used to decrease rates of thumbsucking, vomiting, and stealing.

Hyperactivity—The hyperactivity often associated with neurological deficit has long been thought unamenable to psychological manipulation and has been treated chiefly by administration of a variety of tranquilizing drugs. Positive reinforcement has been used in a classroom setting to control hyperactivity in 9- and 10-year-old boys diagnosed as brain damaged. Because the boys' activities frequently earned them the acclaim of their classmates, the entire class was reinforced for the subjects' desirable responses with a consequent increase in their attending behaviors. Dramatic changes were reported in a group of five hyperactive children by programming the teacher's behavior so that social reinforcers were made contingent upon the occurrence of socially acceptable behavior.

Tics—A technique for the control of tics is massed practice of the behavior voluntarily engaged in by the tiqueur. The conditions under which this technique will be successful have not been established. Unsuccessful outcome may be related to difficulty in policing the massed practice trials in that the experience is fatiguing and aversive for the child who will attempt to avoid the practice session, thereby defeating the treatment attempt. The therapist must also be careful not to inadvertently reinforce the tics, e.g., by marking a record sheet each time the tic occurs.

Self-destructive behavior—Self-injurious behaviors in schizophrenic children have been treated through administration of punishment via electric shock, critical comments, and slapping. With the children's attention focused upon relevant social stimuli, their appropriate behaviors could be more effectively reinforced. Both time out from reinforcement and electric-shock punishment were used to control a variety of self-destructive responses in a 9-year-old psychotic boy. The shock procedure was the more powerful technique. In the course of the avoidance conditioning, the buzzing sound produced by the stock prod used to administer shock acquired secondary reinforcing properties and was used to promote the child's eating and to control his holding saliva in his mouth and persistent clinging to people. Although the main techniques were time-out and punishment, praise was also given the child for his prosocial responses.

Acceleration of Prosocial Behaviors

In some instances, therapists are faced with the prospect of increasing the extent of the child's behavior repertoire, which may be in-

adequate and restricted for his age group. For example, development of motor skills of an awkward and inhibited nursery school boy was enhanced by making his teachers' attention and approval contingent upon his using a play-yard climbing frame. Regressed crawling in a 3-year-old girl was eliminated through differential social reinforcement of her walking, and frequency of peer as opposed to teacher interaction was increased in a socially isolated nursery school girl.

Toilet training—Toilet training is another task apparently facilitated through judicious use of positive renforcement. To increase training efficiency, a transistorized device has been developed which is placed in training pants and automatically activates a tone signal when the child has urinated or defecated. On successive trials the infant is reinforced for elimination closer and closer to the proper location.

The electric alarm method has seen considerable use in the treatment of enuresis. Well-controlled studies have demonstrated the superiority of the bed-buzzer method over unspecified psychotherapy-counseling techniques and no-treatment controls.

Retardation—The instatement and acceleration of prosocial behavior have been accomplished in children displaying severe retardation in learning of social and motor skills. As a dramatic example, a bedridden 18-year-old vegetative idiot was trained to move his arm to earn a food reinforcer. Psychotic and mentally retarded children have been successfully treated for poverty in generalized imitation tendencies, self-help behavior, and speech deficiency. The treatment techniques were combinations of modeling procedures and positive reinforcement for imitation or correct responding.

Multiple Treatment Techniques

These studies have combined manipulations designed to promote adaptive behaviors with attempts to decrease occurrence of problematic behavior. Use of combinations appears to be growing among behavior therapists possibly because the child who displays maladaptive behavior is likely also to have learned relatively few socially desirable means of acquiring the reinforcement which his deviant responses were intended to secure. Under such circumstances, it is possible that apparent "symptom substitution" will occur, with another problem behavior emerging after a treated deviant response has been successfully eliminated, simply because the child's response hierarchies include few prosocial behavior patterns. The therapist can help prevent the appearance of additional problems through teaching the child desirable responses which are likely to be maintained through reinforcement in the child's social situation.

Delinquents—Delinquents typify a group exhibiting a number of undesirable response patterns in combination with a deficiency in prosocial responses. Behavior therapy interventions have involved use of acceleration-deceleration techniques. Time out in an isolation room has been used to control an institutionalized delinquent boy's antisocial behaviors, and at the same time positively reinforce his adaptive behaviors. He was awarded to-

kens which could be turned in for a number of reinforcing events for each hour he managed to remain out of isolation.

A significant increase in adolescent delinquents' cooperative and constructive behaviors has been reported when this class of responses was followed by positive consequences such as verbal praise or a gift. Prosocial behavior was increased in adolescent delinquents through administration of positive reinforcers (small change and cigarettes) on a variable interval schedule. The boys received reinforcement for keeping appointments, appropriately discussing and analyzing their feelings, and performing job-training tasks. Three years after termination of treatment, these subjects showed reduction in criminal offenses as compared to a control group.

Autistic behaviors—Simultaneous use of acceleration and deceleration modification techniques has proved to be a powerful approach to the treatment of particularly maladaptive and resistant behavior patterns, such as those observed in psychotic children. Considerable positive behavior change was produced in a severely autistic 3-year-old boy through a combination of reinforcement (food) and a procedure described as "mild punishment and extinction" which involved isolating the boy in his bedroom contingent upon his having had a temper tantrum. Extinction of fear and aggressive responses as well as increased responsiveness to adult requests in a 9-year-old autistic girl through contingent application of candy, attention, and opportunities to look into a mirror and withdrawal of social reinforcement for undesirable behavior has been reported. Treatment of nonpsychotic children's aggression, storm phobia and anorexia nervosa, school phobia, and operant crying seems to be facilitated through use of acceleration and deceleration techniques.

Parental training—A new technique that seems to have promise is training of parents to become appropriate reinforcement-dispensing agents. Parents are invited to observe reinforcement treatment sessions to see that the reinforcement contingency actually does control their child's behavior, and to learn how and when to dispense reinforcers, both tangible and social. Parents have been successfully trained as behavior therapists for their children's behavior. It is likely that the best hope for permanent positive behavior change rests in modifying the client's social environment. In the case of children, it may prove more efficacious to modify the parents' child-rearing practices than to bring the child to the laboratory or clinic. Parental education of this type may have important preventive aspects in that parents who are aware of the nature of their control of their children's behavior may be able to prevent the occurrence of problems and to promote appropriate interpersonal behavior.

Unfortunately, many of the behavior therapy studies represent no improvement over the traditional clinical case study in terms of experimental rigor. But there is a small but growing number of carefully designed behavior therapy studies which meet most of the evaluation criteria and which demonstrate the power and efficiency of behavioristic treatment approaches.

Accounts

MARVIN B. SCOTT and STANFORD M. LYMAN
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Talk is the fundamental material of human relations. Our concern here is with one feature of talk we call "accounts."

By an account we mean a statement made to explain unanticipated or untoward behavior. An account is not called for when people engage in routine, commonsense behavior in a cultural environment that recognizes that behavior as such.

There are two types of accounts: excuses and justifications. Justifications are accounts in which one accepts responsibility for an act, but denies the pejorative quality associated with it. A soldier may admit that he has killed other men, but deny an immoral act since those he killed were the enemy. Excuses admit that the act is bad, wrong, or inappropriate but deny responsibility. Our soldier could admit the wrongfulness of killing but claim that he is "under orders." We distinguish four forms by which excuses are formulated: appeal to accidents, defeasibility, biological drives, and scapegoating.

Excuses claiming accident mitigate (if not relieve) responsibility by pointing to the hazards in the environment, inefficiency of the body, and the human incapacity to control all motor responses. Excuses based on accidents are most likely to be honored because they do not occur all the time.

Appeals to defeasibility are available because of agreement that all actions contain some "mental element." An individual might excuse himself by claiming that information was not available to h i m , o r b e c a u s e o f m i s-information arising from intentional or innocent misrepresentation. Both will and knowledge can be impaired, the invocation of which ordinarily constitutes an adequate mitigation of responsibility—intoxication (whether from alcohol or drugs) and lunacy (whether temporary or permanent) being examples.

Another excuse invokes biological drives. This is part of a larger category of "fatalistic" forces which in various cultures are deemed to be controlling of some or all events. The invocation of biological drives is commonly an appeal to natural but uncontrollable sexual appetite. Homosexuals frequently account for their deviant sexual desires by invoking the principle of basic biological nature.

Scapegoating is derived from another form of fatalistic reasoning. A person will allege that his questioned behavior is a response to the behavior or attitudes of another.

Like excuses, justifications are socially approved vocabularies that neutralize an act or its consequences. But to justify an act is to assert its positive value in the face of a claim to the contrary.

For a tentative list of types of justifications we turn to "techniques of neutralization." Relevant are techniques of "denial of injury," "denial of victim," "condemnation

of condemners," and "appeal to loyalties."

In denial of injury the actor acknowledges that he did a particular act but asserts that it was permissible since no one was injured, or no one about whom the community need be concerned was involved, or the consequences were trifling.

In denial of the victim the actor expresses the position that the action was permissible since the victim deserved the injury. Four categories of persons are frequently perceived as deserving injury: proximate foes, those who have injured the actor; normatively discrepant roles—homosexuals, whores, pimps; groups with tribal stigmas—racial and ethnic minorities; distant foes—"Whitey," "Reds," "politicians."

Using the device of condemnation of condemners, the actor admits performing an untoward act but asserts its irrelevancy because others commit these and worse acts, and they are not caught, not punished, not condemned, not noticed, or even praised.

In appeal to loyalties the actor asserts that his action was permissible or even right since it served the interests of another to whom he owes an unbreakable allegiance or affection.

Two other sorts of justification may be mentioned: "sad tales" and "self-fulfillment." The sad tale is a selected arrangement of facts that highlight a dismal past, and thus "explain" the individual's present state.

Self-fulfillment is a peculiarly modern type of justification. Interviewing LSD users and homosexuals, we are struck by the prominence of self-fullfillment as the grounds for these activities.

Accounts may be honored or not. If an account is honored, it was efficacious and equilibrium is restored. One variable governing the honoring of an account is the character of the social circle in which it is introduced. Vocabularies of accounts are likely to be routinized within cultures, subcultures, and groups, and some are likely to be exclusive to the circle in which they are employed.

Asked why he is listless and depressed, a person may reply, "I have family troubles." The remark will be taken as an account that will probably be honored, because "everyone knows" that "family problems" are a cause of depression. Accounts can fit a variety of situations. In response to questions—Why don't you get married? Why are you in a fit of depression? Why are you drinking so heavily?—the individual can respond with "I'm having family problems."

In interacting with others, the socialized person learns a repertoire of background expectations that are appropriate for a variety of others. A wife may respond sympathetically to her depressed husband because his football team lost a game, but such an account will appear bizarre when offered to one's boss. The incapacity to invoke situationally appropriate accounts will often be taken as a sign of mental illness. The person who is labeled ill has been behaving "stupidly" in terms of his culture and society: he offers accounts not appropriate according to culturally defined background expectations.

An account can be discredited by the appearance of the person offering an account. When a girl accounts for her late return from a date by saying the movie was over-

long, her mother may discredit it noting the daughter's flushed appearance. Since individuals are aware that appearances may serve to credit or discredit accounts, efforts are made to control these appearances through a vast repertoire of "impression management" activities.

When an account is not honored, it will be regarded as either illegitimate or unreasonable. An account is treated as illegitimate when the gravity of the event exceeds that of the account or when it is offered in a circle where its vocabulary of motives is unacceptable. Accidentally allowing a pet turtle to drown may be forgiven, but accidentally allowing the baby to drown may not easily be excused.

An account is unreasonable when the stated grounds for action cannot be "normalized" in terms of the background expectancies of what "everybody knows." When a secretary explained that she placed her arm in a lighted oven because voices had commanded her to do so, the account was held to be grounds for commitment to an asylum. In general, those who persist in giving unreasonable accounts are likely to be labelled as mentally ill. Unreasonable accounts are one of the sure indicies by which the mentally ill are apprehended. Conversely, persons labeled as mentally ill may relieve themselves of the consequences of that label by recognizing before their psychiatrists the truth value of the label, by reconstructing their past to explain how they came to deviate from normal patterns, and by gradually coming to give acceptable accounts for their behavior.

Organizations systematically provide accounts for their members in a variety of situations. The rules of bureaucracy make available accounts for actions taken toward clients—actions which, from the viewpoint of the client, are untoward. When people say they must perform a particular action because it is a rule of the organization, the account is regarded as reasonable, since "everyone knows" that people follow rules. The gravity of the event may discredit such accounts, as the trials of Nazi war criminals illustrate.

Under certain situations behavior that would require an account is normalized without interruption or any call for an account. Two values that may override the requirement of accounts are sociability and information.

In the case of sociability the desire that the interactional circle be uninterrupted calls for each interactant to weigh whether or not the calling for an account might disrupt the entire engagement. When the gathering is convivial, the participants may overlook errors, inept statements, lies, or discrepancies in the statements of others.

In some engagements the interactants seek to obtain information which is incidental, but which might be withheld if any of the speaker's statements were called into account. Among adolescent boys it is inappropriate to challenge a speaker describing his sexual exploits since, no matter how embellished and exaggerated the account might be, it permits the hearers to glean knowledge about sex.

Accounts also differ in form or style. We may distinguish five linguistic styles—intimate, casual, consultative, formal, and frozen.

The intimate style is employed

among persons who share a deep, intense and personal relationship—lovers, a married pair, or very close friends. The verbal style employs single sounds or words and jargon to communicate whole ideas.

The casual style is used among peers, ingroup members, and insiders. It employs ellipses and slang. Background information is taken for granted and may be merely alluded to. Intimate and casual styles differ only in degree and suggest a slight but significant difference in social distance among the interactants.

Consultative style is employed when the amount of knowledge available to one of the interactants is unknown or problematic to the others. There is a definite element of "objectivity." In response to the question, "Why are you smoking marijuana?" the individual might reply, "because everybody who's read the LaGuardia Report knows that it's not habit forming." But a casual response might be "Don't be square."

Formal style is employed when the group is too large for informal coparticipation to be a continuous part of the interaction. Listeners must wait their turn to respond, or, if they interject comments, know that this will be an untoward event, requiring some kind of restructuring of the situation. Speaker and audience are in an active and a passive role, and, if the group is large enough, may be obligated to speak or remain silent according to preestablished codes of procedure. Such situations occur in bureaucratic organizations between persons in hierarchically differentiated statuses, or in the courtroom, in the interaction between judge and defendant.

Frozen style is an extreme form of formal style employed among those who are required to interact and yet remain social strangers. Pilots communicate to scanners in a control tower in the same style as prisoners of war to their captors or telephone operators to angered clients. Often the frozen accounts offered are tutored, memorized, or written in advance, and may be applicable to a variety of situations.

The vulnerability of actors to questions concerning their conduct varies with the situation and the status of the actors. Where hierarchies of authority govern the situation, the institutionalized office may eliminate the necessity of an account or even prevent the question from arising. Military officers are shielded from accountability to their subordinates. When cultural distance and hierarchy are combined, those enjoying the superior status are privileged to leave their subordinates in a perplexed and frightened state.

Besides the invulnerability to giving accounts are the strategies that can prevent their announcement. These strategies are meta-accounts; three are prominent: mystification, referral, and identity switching.

When mystification is employed an actor admits that he is not meeting expectations, but follows this by pointing out that, although there are reasons, he cannot tell.

Certain statuses suggest mystification: in addition to charismatic leaders and experts at occult or little-understood arts are all those statuses characterized by specialized information including (but not limited to) doctors, lawyers, and spies.

Using the strategy of referral,

the individual says, "I know I'm not meeting your expectations but if you wish to know why, please see . . ." Referral is a strategy available to the sick and the subordinate.

Illness, especially mental illness, allows the sick person to refer inquiries about his behavior to his doctor or psychiatrist. Group referral arises when accounts for the behavior of a whole people are avoided by sending the interrogator to the experts. Juvenile delinquents refer inquiries to social workers, Hopi Indians to anthropologists, and unwed Negro mothers to the Moynihan Report.

In identity switching, ego indicates to alter that he is not playing the role that alter believes he is playing. This is a way of saying, "You do not know who I am." This technique is readily available since all individuals possess a multiplicity of identities.

Accounts always occur between persons in roles—husband and wife, doctor and patient, teacher and student, etc. A normative structure governs the nature and types of communication between the interactants, including whether and in what manner accounts may be required and given, honored or discredited.

The identities of speaker and audience will be negotiated as part of the encounter. Each of the interactants has a stake in the negotiations since the outcomes will often depend on these preestablished identities. In competitive situations the interactants will seek to maximize gains or minimize losses, and part of the strategy will be to assume and accept advantageous identities, refusing those roles that are disadvantageous.

The most elementary form of identification is that of human and fellow human negotiated by the immediate perceptions of strangers who engage in abrupt and involuntary engagements. Once two objects on a street collide and mutually perceive one another to be humans, an apology will suffice. Those persons not privileged with full or accurate perception—blind, myopic, or blind-folded—are not in a position to ascertain whether the object with which they have collided is eligible to call for an account and deserve an apology. In overcompensating, the persons may indiscriminately offer apologies to everyone and everything with which they collide.

Some objects are ambiguously defined with respect to their deserving of accounts. Dogs and cats are sometimes eligible for apologies and excuses when they are trodden upon by their masters. But insects and large beasts do not appear to be eligible even when they are trodden upon by unwary (Occidental) humans.

Racial minorities in caste societies often insist to no avail on the priority of their identity as "human beings" over their identification as members of a racial group. Indeed the "Negro human-being" role choice dilemma is but one instance of a particular form of strategy in the negotiation of identities.

Once identities have been established and an account offered, the individual has committed himself to an identity and assumed the assets and liabilities of that role for the duration of the encounter. If he wishes to shift accounts to one appropriate to another identity he may also need to account for the switch in identities.

Identity switching has dangers, since it casts doubt on the attachment the claimant had to his prior identity, and his attachment may have been a crucial element in the acceptability of his first account. The hearer of an account may have a vested interest in accepting the entire range of accounts and may thus accommodate or even facilitate the switch in identities.

In ordinary life, accounts are usually "phased." One account generates the question which gives rise to another; the new account requires renegotiation of identities; the identities necessitate excuses or justifications, improvisation and alter-casting; another account is given; another question arises, and so on.

Perhaps the most immediate task for research in this area is to specify the background expectations that determine the range of accounts deemed appropriate to a variety of situations. We want to know how the actors take bits and pieces of words and appearances and put them together to produce a perceivedly normal (or abnormal) state of affairs. This kind of inquiry involves a study of background expectations. On the basis of such investigations, the analyst should be able to provide a set of instructions on "how to give an account" that would be taken by other actors as "normal." These instructions would specify how different categories of statuses affect the honoring of an account, and what categories of statuses can use what kinds of accounts.

Future research may take as a unit of analysis the speech community. Speech communities define for their members the appropriate lingual forms to be used among themselves. The everyday language of lower-class teenage gangs differs from that of the social workers who interview them.

An individual may belong to several speech communities at the same time or in the course of a lifetime. Some linguistic devices (such as teenage argot) are appropriate only to certain age groups and are discarded; others, such as those used by lawyers in the presence of judges, are appropriate to certain status sets and are employed and discarded as the individual moves in and out of interactions with his status partners. Some individuals are dwellers in but a single speech community. The aged and enfeebled members of class or ethnic ghettoes are an example. Others are constant movers through differing speech communities.

Since it is with respect to deviant behavior that we call for accounts, the study of deviance and the study of accounts are intrinsically related, and a clarification of accounts will constitute a clarification of deviant phenomena—to the extent that deviance is considered in an interactional framework.

Comprehensive Management of Psychiatric Emergencies

SHERVERT H. FRAZIER

Psychosomatics, 9 (1) :7–11, 1968

There are two types of psychiatric emergencies: intrapsychic and social. The intrapsychic emergency emanates from an individual's malfunctioning in his life situation, and the social emergency emanates from the malfunctioning of a social group of people.

Only a few kinds of behavior seem to be accepted as constituting or implying a psychiatric emergency; suicidal behavior, assaultiveness, property destruction, extreme anxiety, panic, and bizarre behavior. The first three are almost invariably considered an emergency, and usually a friend, relative, policeman, clergyman, family physician, or other agent will intervene. Whether anxiety, panic, or bizarre behavior is perceived as an emergency depends on the degree to which the disturbed behavior threatens or evokes fear in the beholder. Classification as a psychiatric emergency seems contingent on one's being conceived of as a social emergency.

A vanishing element in our social structure is "Tender Loving Care." This is a basic human need that should be recognized and provided in management of psychiatric emergencies. It should be followed with a physical examination, psychiatric examination, psychological testing, and a mental status examination.

Suicide-potential persons—Evidence of suicide risk in depressed and schizophrenic persons should be known to all staff of emergency services, and treatment and disposition should be planned so as to reduce the risk to a minimum. This includes setting up ordinary precautions while the person is in the hospital and acquainting his family with the facts of the illness. Persons admitted because they have inflicted injuries on themselves should never be released without psychiatric evaluation. Hospitals which prohibit admission of psychiatric patients should update their policies in recognition of the fact that persons intent on suicide are likely to be ill and to require and deserve treatment. No would-be suicide should ever be retained in jail. There should be a 24-hour-a-day telephone service to provide assistance to those who seek help for themselves or others because of suicidal ideas.

Aggressive patients—Those believed to be dangerous should be dealt with by professionals who have had exposure to behavior of patients and training in handling highly disturbed people. Because most patients experience extreme fear, they can become dangerous when confronted with ambiguous, confusing, belligerent, or threatening treatment. There should be a close and friendly relationship between the emergency service and the police.

General principles of management—The first principle is prompt action appropriate for the particular situation. The disturbed, excited, panicky or unruly patient

must be accepted as he is. Supportive personal human contact should be provided—talking to the patient, staying with him, assigning others to stay with him.

It is better to do too much than too little. Most patients in acute upsets have regressed to a childlike level. This may be difficult to recognize, especially if one knows the person, and the usual error is to expect too much.

Appropriate specific treatment—The majority of emergent patients respond to supportive treatment such as talking, rest, sedation, and where indicated, food and fluids.

Impulse handling—Anxiety is experienced as danger to the self, which may be seen as arising from within or from without. In either circumstance the self-image is weak and ineffective, and this feeling is experienced as a loss of self-confidence leading to a need for help from others which may be communicated nonverbally and verbally. This state is responded to psychically and behaviorally with efforts to reestablish a more effective object relationship and thereby strengthen the self.

Self-esteem—The psychic apparatus assumes the task of organizing perception and information, to anticipate and ward off injury which may threaten from the external environment or from the pressure of drives originating within. This function includes elaboration of alerting and emergency systems, to anticipate or deal with crises, as well as psychological mechanisms of defense that monitor, control, modify, relate, integrate, or synthesize the input from the external environment, the internal environment, and the data of past experience so that the conditions for living can be assured with due regard for external and internal reality. It is through the defensive activities of the psychic apparatus that adaptation is achieved and motility, in relation to the external environment, is controlled.

Prevention—Home visits can sometimes eliminate need for hospitalizing emergent patients. Intervention during a crisis may benefit the person's mental health by ensuring a healthy resolution of the crises. Predictable crises, such as those precipitated by surgical operations, parenthood, college entry, etc., may be handled by anticipatory guidance in which the specialist helps the people rehearse the emotional situations in which they will find themselves. Special training should be available to care-giving professionals—doctors, nurses, teachers, clergymen—so that they may intervene in crises as part of their everyday work.

The crisis of mental illness is most often preceded by many smaller crises of lesser dimension. If these smaller crises could be intelligently and responsibly answered, much serious mental disruption could be averted. Early detection and prevention are a necessary inclusion in any effective mental health program.

Specific areas of prevention are: All psychiatric residency programs should include education for handling psychiatric emergencies; service should be immediately available; every State and community should develop followup programs that provide medication, counseling, and access to rehabilitation, educate the patient to his need for continued care, and follow up those patients who cannot or will not follow up the program.

Visual Evoked Response and Frequency Density Spectra of Prisoner Patients

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Comprehensive Psychiatry, 9 (1) :62–70, 1968

There has been speculation about a possible neurophysiological deviation in antisocial individuals. The usual examinations, including scalp EEG, have been inconclusive. Availability of new methods such as the visual evoked response and frequency density spectra has made it feasible to investigate the problem further.

The experimental group was 14 male prisoner-patients on the Maximum Security Service of Saint Elizabeths Hospital. All subjects had had multiple arrests. All but one had been acquitted by reason of insanity in the U.S. District Court for the District of Columbia.

Controls were 14 nonpatient employees (10 males and 4 females) from the professional, clerical, and technical staff. They had no known history of psychiatric illness or criminal behavior and were matched for age with each patient; there was no known physical illness and no suggestion of organic brain damage.

The light flashes used as stimuli were produced by a photic stimulator placed 6 inches in front of the closed eyes of the reclining subject in a darkened room. Stimuli occurred singly and in pairs with intervals between them of 25, 30, 35, 40, 60, 80, 100, 120, 140 msec. in random order. Singles and pairs were presented at intervals varying between 1–1.5 seconds.

There were three measures on which prisoner-patients differed significantly from controls: increased amplitude of response to single and 30 msec. paired light flashes; greater incidence of temporal theta activity; a tendency to lack of change in spectral density pattern during stimulation as compared to the "resting" state.

Inspection of individual patient records showed no apparent differences which could be correlated with diagnosis or known behavioral characteristics.

These tentative findings are consistent with the ubiquitous but elusive concept that the nervous system of sociopaths may be hyperexcitable and/or "immature."

Evoked responses are virtually impossible to detect in the usual EEG recording because of the presence of the spontaneous background activity and low voltage of the evoked signal. Computer methods have the advantage of being able to detect the presence of low voltage signals in the presence of spontaneous background activity and of separating simultaneously occurring frequencies. Both the evoked response and changes in spectra with stimulation give information about the functioning of the nervous system, whereas the "resting" EEG gives information about the state of the cell populations under the electrodes. It is possible that correlations with behavior are more apt to be found by examination of the changes which occur during stimulation or problem solving than by studying the background activity alone. Computer methods show promise of answering some clinical problems.

Fatal Accidents: The Role of Psychopathology, Social Stress, and Acute Disturbance

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American Journal of Psychiatry, 124 (8):1028–1036, 1968

A study of 96 drivers responsible for fatal vehicular accidents (F drivers) during a 3-year period in Washtenaw County, Michigan, offered an opportunity to explore the role of emotional illness in drivers responsible for fatal traffic accidents. Some months after each fatal accident, the driver's significant others and employers were interviewed. If the driver survived, he was interviewed. The arrest and traffic records of all 96 drivers were obtained from the Michigan State Police and Michigan Department of State. A control sample of 96 drivers matched for age, sex, and home county was drawn from driver registration files. The controls and their significant others were interviewed and their records obtained.

Of the 96 F drivers, 22 were paranoid, as were 4 controls, a greater than 5 to 1 disparity. Nine F drivers and 1 control were classified as suicidal; 20 F drivers and 7 controls were clinically depressed.

If the emotional problems of certain of the F drivers had contributed to their causing a fatal accident, one could expect that these chronic "behavioral" symptoms would be reflected in the drivers' earlier driving records. In each symptom category the F drivers had at least 50 percent more prior accidents than those who did not have the symptoms. The suicidal and depressed drivers had approximately twice as many accidents as the nonsuicidal and nondepressed drivers.

Turning to serious accidents, a similar consistency prevailed. The symptomatic F drivers averaged twice the number of serious accidents as their nonsymptomatic counterparts except for the violent group.

Social stress for the F and control drivers was measured in terms of personal crises or vocational-financial stress. Personal crises were defined as interpersonal events severely disturbing to the driver which arose during the 12-month period preceding the fatal accident (or 12-month period prior to the interview of the control driver), which still affected the driver at the time of the fatal accident or interview.

Vocational and financial stress included all disturbing job problems or financial difficulties during the same 12-month period which were still a source of aggravation at the time of the accident or interview for the F and control drivers.

The differences in personal conflict and combined vocational-financial stress between the F and control groups were significant.

One set of data turned up unexpectedly in our interview summaries. No less than 20 percent of the 96 fatality drivers were acutely upset by events that occurred during the 6-hour period immediately preceding the accident. Most had had violent quarrels, for the most part with women. A few had physical fights with other men. Since no control study is available, it is difficult to evaluate this finding, but we suspect it will have relevance.

The Evaluation of a Suicide Prevention Scheme by an Ecological Method

CHRISTOPHER BAGLEY

Social Science and Medicine, 2 (1) :1–14, 1968

It is a crucial task of social science to integrate the diverse and often conflicting accounts of the causes and associations of suicide into an integrated model which can offer explanatory hypotheses about suicide cause and prevention.

Given a working hypothesis that suicide is caused by the interaction of a number of variables, a program for prevention should operate at the level of maximum utility, aiming to influence those factors which are easiest to influence, and are of major importance in precipitating suicide. The major influence on suicide would seem to be the variable of status integration. On this basis, suicide could be prevented by controlling the speed of social change, or the tendency of change in social systems to place individuals in isolated roles. Seeking to change the fundamental value system of societies is likely to be an immensely difficult task.

The social prevention of suicide has two avenues left: ending "alienative" suicide by providing social and financial support for aged and physically handicapped individuals and providing supporting networks within local communities to help socially isolated individuals.

In 1953, a clergyman initiated the Samaritan movement from his church in London. There has been a rapid expansion of these schemes in British towns. The Samaritan schemes publicize a telephone number which those tempted to commit suicide may ring, day or night. Personnel operating this scheme usually have no professional training, but are clergy or intelligent laymen who have undergone short training specific to the Samaritan scheme. Often a psychiatric social worker acts as consultant and arranges the training. A principal aim is to give the workers the aptitude to judge when a client needs referral to a specialist in psychiatric or physical medicine.

The Samaritans offer simple, nondirectional psychotherapy, and the client is encouraged to talk about, and even "talk-out" his problems. Where possible, social support is provided, and sometimes the client joins the ranks of those giving support to the potential suicides, forming a social group somewhat similar to Alcoholics Anonymous.

If an experiment (of the ex post facto type, which is the only design available in these circumstances) produces a positive result, and intervening variables which might account for the result are eliminated, the result must be given some credence. In practical terms, if suicide rates in Samaritan towns show a significant decline when compared with the rate in matched control towns, the possibility that the decline is due to the operation of the Samaritan schemes must be seriously considered.

The criterion for selection of Samaritan towns was that the scheme had been in operation for at least two years before the last year (1964) for which suicide statistics were available at the time

the study was carried out. Fifteen towns in England and Wales fulfilled this criterion.

The control towns were the closest economic, social, and demographic matches that it was possible to obtain, given present knowledge of urban characteristics. The average suicide rate for the same number of years before the inception of the Samaritan scheme (and a similar period in the control) was compared with the rate in the same number of years after the scheme up to the present availability of statistics.

In the control towns there was an increase of nearly 20 percent in the suicide rate—much higher than the increase in the suicide rate in the country as a whole.

These results point to the conclusion that Samaritan schemes are associated with a reduction in the suicide rate in the towns in which they operate—even when the actual rate rises, this adverse change is usually less than in the control town.

It remains to be considered whether or not there is a causal association between the Samaritan schemes and the reduced suicide rate. It is possible that the development of a value climate which creates social cohesion also promotes the development of a Samaritan scheme, so that both the reduction of suicide and the Samaritan scheme itself are artefacts of culture.

The alternative view of the operation of Samaritan schemes is that their basis is not cultural but structural. The structural view assumes a kind of social behaviorism: that social action is a response to a particular stimulus in the environment. On this view, the hypothetical basis of Samaritan schemes is the fortuitous setting up of the scheme by a charismatic figure who gathers together a small band of workers and initiates the scheme. The ill, isolated, or neurotic individuals who are motivated towards suicide make telephone contact with the Samaritans. As the organization grows, it gains publicity and personnel leading to a decline in the suicide rate. By this argument, the Samaritans are causally responsible for this decline.

One possible objection to a causal association is that the kind of person whom the Samaritans deal with is different from the typical successful suicide. But it is possible that the very existence of the Samaritan scheme might prevent an individual from committing suicide, even though he had no actual contact with the organization. Another possibility is that the Samaritan schemes reduce the number of attempted suicides, and the reduction in the rate is due in consequence to the reduction in the number of attempted suicides which are accidentally successful.

The conclusion must be that the evidence points to the possibility, although it by no means offers proof, that Samaritan schemes may directly lower suicide rates. Certainly, these results offer a rationale for the continued extension of the Samaritan schemes.

It is possible that the schemes may also have been effective in the relief of misery in persons who entertain thoughts of self-destruction but who do not actually reach the point of suicide. The measurement of this kind of gain in mental health must probably be based on a detailed examination of individual cases.

A Junior High School Seminar on Dangerous Drugs & Narcotics

BARBARA B. JOHNSON

Journal of School Health, 37 (2) : 84–87, 1968

Assigned to Bancroft Junior High School by the San Leandro Unified School District is the "mandate" from the California Department of Education that each school district must teach students about the physiological and social dangers and ill effects of tobacco, alcohol, communicable diseases, and dangerous drugs. We have been presenting each of these topics in a program of two-day "Seminars." We share information and attitudes through informed speakers, films, panel and group discussions, plus student participation, with the student body of 8th- and 9th-graders.

Our plans turned away from the usual approach ("the horrors of life as a heroin addict") and towards problems and decisions facing our students (yes, really facing 13- and 14-year-olds): glue sniffing, pills (bennies, goofballs), pot (marijuana), "trip" (LSD). We interpreted our basic charge as the need to help each student establish a set of values, to look at himself in *his* world, to look at his peers, to determine what *he* was going to do when faced with decisions about the use of these dangerous drugs. We knew we needed to approach this matter in some other way than by preaching—which results in students *not* listening. We hoped to show how good decisions are made by becoming informed and by weighing alternatives.

Conferences with experienced people strengthened and reaffirmed the plan.

Stage I.—Discussions in English classes (chosen as the most intimate class, familiar with the discussion method). The teachers were asked to divide the classes into groups of six or seven students with a student leader and recorder. The students were urged to speak freely as they thought and felt (not what they thought they should say). Their responses were to remain anonymous. There would be a panel of experienced people who would try to answer their questions and clarify any misunderstandings.

Discussion leaders were asked to: Encourage every member to speak; insist that members remain courteous; urge each member to be as honest and as accurate as he could; remind students that no names would be used by the recorder; present each of the following statements for discussion by asking "What is your reaction to these statements? People have different ideas about pills, LSD, marijuana, glue sniffing. Some people think smoking marijuana is not dangerous. It will/will not do any good to arrest people for using or selling drugs. Some students in our town use drugs. I feel that I will never use drugs. I feel that I might try certain drugs. I would like to know these things about drugs."

Recorders were asked to recognize important points and record them accurately yet keeping all comments anonymous. They were asked to indicate group support or nonsupport of any reaction including reasons. These were then sum-

marized by the committee.

I would like to know these things about dangerous drugs: What do they do to you? Effect on life expectancy, on the brain, on sexual ability; do they cause defects in unborn babies, can they wreck your life, what does it mean to be on a "trip"? What are the effects of glue, bennies, dexadrine, crystals, pot, cough syrup? Which are addictive? Why illegal when alcohol is not?

What effects on personality, can you do things better, do they free the inhibitions? Do people take them because they have problems at home or school and do not want to face reality?

In response to the statement "Will I ever use drugs?" Most students responded "no"—however, they qualified with "Well, maybe marijuana or pills, nothing to do with needles," "Not glue—it wrecks your mind," "Everybody else is taking it," "This day and age everybody will most likely use drugs at least once." The most prevalent belief was that marijuana is the least dangerous and the one they will most likely try, if any. Many believe it helps gain and hold friends.

Stage II. Panel presentation to students—A panel of experienced persons responded to the student questions and attitudes in two assemblies, by grade level. This presentation was disappointing. Students felt that their questions were not answered, that the discussion was not related to students' immediate environment, that panelists spoke either "above" or "below" the students (a strong resentment toward adults speaking down to them or using "hip" language). For next year the committee has recommended that we include students as part of the panel discussions; ask students to interview the experts, either in front of their peers or in small groups with a report back to their peers. This idea results from the mature and thoughtful response of most students in the English class discussions.

Stage III. Film: "Narcotics—Pit of Despair"—This film seemed to be an effective means of communication. Student comments included "It didn't say don't, it just showed what happens and left the decision up to you," "It showed how one stimulant led to another more dangerous one," "Showed how hard it is to stop," "Showed how drugs can wreck your life," "Should have included LSD."

Stage IV. Summary and evaluation in English classes—Sixty-five percent of the students responded favorably to the preliminary discussions held in English classes.

The majority (83 percent in 8th grade, 66 percent in 9th grade) felt that the seminar had added to their knowledge of drugs and narcotics. About the same percent felt that the seminar influenced them against letting drugs be a part of their lives.

We feel that we presented graphically, dramatically, and forcefully the idea that one must make decisions, that others are also doing this, that these decisions are made best if one examines the pertinent information, hears others on the subject, takes time to weigh alternatives, sees himself in relation to those about him, before he finally comes to his decision. Perhaps our senior high school will assist us in making a followup study in two or three years. We feel that we "reached" most of these young people at a time when we had influence towards the goal of avoiding the use of dangerous drugs.

Effects of Acetoxycycloheximide on Learning and Memory of a Light-Dark Discrimination

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Nature, 218 (No. 5138) : 271–273, 1968

We have reported studies which show that cerebral protein synthesis may be necessary for "long-term" memory but not for learning or "short-term" memory. Mice whose cerebral protein synthesis at the time of training had been inhibited by intracerebral injections of acetoxycycloheximide learned a left-right discrimination in a T maze normally, remembered normally 3 hours after training, but had marked impairment of memory 6 hours or more after training. It seemed worthwhile to determine the effects of acetoxycycloheximide on learning and memory of a more difficult task.

Male Swiss albino mice (30–40 g, 2–3 months old) were anesthetized with ether, mounted in a stereotaxic instrument and injected in both temporal regions of the brain with 20 μl. of 0.15 N sodium chloride with or without a total of 20 μg. of acetoxycycloheximide.

The rear wall of a T maze was lined with white paper and a section of black cardboard half the size of the rear wall was mounted on the rear wall so that it could be moved from side to side. The white side was illuminated and the position of the lighted side was randomly varied. The mouse was placed in the maze, and 5 seconds later a shock was applied through the grid floor. The shock ended when the mouse entered the lighted side; each trial was continued until the lighted side had been entered. Training was conducted to a criterion of either five out of six, nine out of ten, or fifteen out of sixteen consecutive correct responses.

Mice injected with acetoxycycloheximide learned to these criteria in the same number of trials as those injected with saline.

Mice injected with acetoxycyloheximide remembered as well as mice injected with saline when tested 3 hours after training.

But when tested 6 hours or more after training, mice injected with acetoxycycloheximide had impaired retention whereas mice injected with saline showed substantial retention.

We also studied the effects of acetoxycycloheximide given 30 minutes before training. At the time of training, overall inhibition of cerebral protein synthesis would be expected to be less than 60 percent but those sites rapidly exposed to the drug would be expected to be more extensively inhibited. We found that mice trained 30 minutes after injection had recovered sufficiently to learn normally and, when tested for retention, had much less impairment than mice trained 5 hours after administration of the drug.

We conclude that learning and "short-term" memory, that is, memory lasting for at least 3 hours after training, are not dependent on cerebral protein synthesis but that "long-term" memory apparently is dependent on cerebral protein synthesis either at the time of training or within several hours afterwards.

Mental Health News Digests

Human Sexuality

A task force has been established to help the NIMH in developing a broad program for the study of human sexuality, especially homosexuality. The task force will encourage outstanding scientists to conduct research, including in-depth longitudinal studies of effects of early experience on later development of gender identity. They will examine current laws and practices through which society deals with sexual problems as well as the effects of such policies on individuals.

Chairman of the task force is Dr. Evelyn Hooker, University of California at Los Angeles. Members are Dr. Edward Auer, St. Louis University; Judge David Bazelon, U.S. Court of Appeals; Dr. Clellan Ford, Yale University; Dr. Jerome Frank, Johns Hopkins University; Dr. Paul Gebhard, Institute for Sex Research, Indiana University; Dr. Seward Hiltner, Princeton Theological Seminary; Dr. Robert Katz, Hebrew Union College; Dr. Judd Marmor, Cedars-Sinai Medical Center, Los Angeles; Dr. John Money, Johns Hopkins University; The Honorable Morris Ploscowe, New York University; Dr. Henry W. Riecken, Social Science Research Council; Dr. Edwin Schur, Tufts University; Dr. Anthony F.C. Wallace, University of Pennsylvania; and Dr. Stanton Wheeler, Russell Sage Foundation.

NIMH Information System

The National Institute of Mental Health is now preparing 500-word summaries of its major programs. Within the next year, all extramural and training projects—about 4,000—will have been summarized. These descriptions will be processed on the Institute's computer and will be selectively retrieved by means of an existing classification system that identifies major program areas. This is the first stage in the development of a total NIMH information system.

Conference on Mental Health Statistics

A National Conference on Mental Health Statistics was held in Atlanta, Georgia on April 23–26, 1968. Participants were mental health statisticians in State mental health programs, as well as statisticians and epidemiologists from universities, professional organizations, and a contingent from NIMH.

Among the topics reported and discussed were data systems and their application to current mental health programs; data needs for comprehensive health planning; evaluation activities of a community mental health program; data systems for comprehensive mental health services; national reporting of mental health data; the NIMH field stations; psychiatric case registers; and the revised psychiatric diagnostic classification.

The conference was arranged by the Biometry Branch, Office of Program Planning and Evaluation, National Institute of Mental Health.

Review of Laws on Alcohol and Alcoholism

The Legislative Drafting Research Fund of Columbia University is reviewing laws in effect throughout the country relating to alcohol and alcoholism, and is also

preparing a model statute dealing with alcoholism. It will consider the problems of mandatory treatment, civil commitment, and the relation to mental illness laws.

In 1966 the President's Commission on Law Enforcement and Administration of Justice and the President's Commission on Crime in the District of Columbia both recommended the elimination of public drunkenness statutes. The project will study various possible ramifications of such action by States and communities.

The project is being done under a contract with NIMH, and Professor Frank P. Grad of the Legislative Drafting Research Fund is project director.

Industrial Alcoholism Project

New York State will conduct a three-year demonstration project to rehabilitate employed alcoholics in the Albany area and to provide guidelines for development of industrial alcoholism programs throughout the State. The project includes a public education effort by the State Department of Mental Hygiene and an outpatient clinic at Albany Medical College for education and treatment of alcoholic patients.

Patients are given medical and laboratory workups, drug therapy, individual psychotherapy, and medical counseling. They also receive social casework services, public health nursing, and information on Alcoholics Anonymous. The clinic provides education aimed at employee and family understanding of alcoholism as a progressive but treatable illness. Clinic staff includes a physician, psychiatrist, psychologists, public health nurse, psychiatric social worker, rehabilitation counselors, and group therapists. The clinic accepts individual cases who apply for treatment as well as cases referred to it by the industrial community.

Research on Alcoholism

A comprehensive study of the biochemical and psychological aspects of alcoholism has been undertaken by the Houston (Texas) State Psychiatric Institute. The research will be divided into two phases. The first will concentrate on determining whether alcoholics have certain physiological aberrations that predispose them to chronic alcoholism. If such aberrations do exist, the investigators will attempt to develop chemical or pharmacological agents to prevent the advent of the illness.

The second aspect of the research will study neurochemical, endocrinological, and metabolic reactions during the various phases of alcoholism and develop treatments that would be effective in alleviating these changes.

Dr. William M. McIsaac, Director of the Biological Research Division and Chief of Neurochemistry at the Houston State Psychiatric Institute is the principal investigator.

Alcohol, Drugs, and Accidents

The State health department in Minnesota has begun a study of the relationship of alcohol and other drugs to highway accidents. Analysis of postmortem blood samples submitted by coroners will be made to determine the content of alcohol and some selected drugs in the blood of persons who die within four hours of a highway accident. Tests will be run routinely for carbon monoxides and barbi-

turates. A 1967 law requires coroners to make tests for the presence of alcohols and other drugs in highway accident fatalities. The State health department will provide coroners with kits and instructions on how to take proper blood samples, and the samples will be sent to the State health department for analysis. This uniform method of collection will insure more accurate test results.

Mental Health in the Classroom

"Mental Health in the Classroom," the report of the Committee on Mental Health in the Classroom of the American School Health Association, appears in the May 1968 issue of the *Journal of School Health*. Submitted as suggestions to school personnel responsible for classroom teaching, the report may also be helpful to resource personnel in schools, the school nurse, dentist, physician, or community health representatives. It contains suggestions for teaching mental health in kindergarten through Grade 14, and includes information on instructional materials, an extensive bibliography, and a list of audiovisual materials. Copies of the report may be obtained from the American School Health Association, 515 E. Main Street, Kent, Ohio 44240. The price is $2.50 for single copies and $2.00 a copy for orders of 10 or more copies.

Index to Social Service Review

The March 1968 issue of the *Social Service Review* is a 40-year index (1927–66) to the journal. It contains an author index, subject index, and an index of book reviews and reviews of government reports and public documents. Copies may be obtained from the University of Chicago Press, 5750 Ellis Avenue, Chicago, Illinois 60637 for $5.00 (paper); $8.00 (cloth).

Traffic Safety

The Report of the Secretary's Advisory Committee on Traffic Safety has now been published. The Committee was established in 1966 by the Secretary of the Department of Health, Education, and Welfare to review the short- and long-range traffic safety programs of the U.S. Public Health Service, to review the relationship of these programs to those of other Departments, and to make recommendations for expanded programs.

The report is concerned with such topics as a national program of emergency medical services, driver education and training, accidents and alcoholism, crashes and violent behavior, use of seat belts, and the impact of traffic accidents on the legal system. That the National Institute of Mental Health establish a center for study of violent behavior is one of the Committee's recommendations.

The Report may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402, for 50¢.

Psychoanalytic Literature Index

The Institute for Psychoanalysis in Chicago has developed an extensive index of the literature in psychoanalysis, psychosomatic medicine, and related areas of behavioral sciences. It was begun in 1958 when the Institute reproduced the card catalog of its library and made copies available to other academic libraries. Since then regular

monthly supplements have been issued in collaboration with the library of the New York Psychoanalytic Institute, whose cards are added to each month's supplement.

The Index consists of two sets of cards: the first, covering books and 140 serial publications, lists authors, titles, and editors; the second is a subject index based on an actual reading of all articles, monographs, symposia, abstracts of meetings and workshops, etc., and not merely on titles or summaries. The catalog now consists of some 70,000 entries (cards), 50,000 of which comprise the subject index.

Information, including costs, about the Index may be obtained from Dr. George H. Pollock, Institute for Psychoanalysis, 180 N. Michigan Ave., Chicago, Illinois 60601.

Psychiatric Outpatient Centers of America

"Psychiatric Outpatient Centers of America" is an organization founded in 1963 to bring together mental health centers in rural areas, small communities, and large cities in the U.S., Canada, and Mexico. It invites the participation of outpatient clinics of all types, whether they be long established or newly organized, all-purpose or in service of a special clientele.

Its primary aim is to be of service to outpatient centers in ways that are practical and informal. It is not a "standard" setting or certifying group. POCA publishes a newsletter, *Hotline,* and a quarterly magazine, *POCA Press,* as well as conference proceedings.

Membership applications are accepted from outpatient centers and from individuals. Annual dues for clinic membership are $25. Clinic membership entitles a center to one official delegate who votes on its behalf on policy and constitutional matters and to elect officers. Individual members do not vote, but may be nominated, elected, or appointed to office. A national conference is held every year in a different city.

Inquiries about POCA may be addressed to Richard W. Loring, Executive Secretary, POCA, 202 East Bissell Avenue, Oil City, Pennsylvania 16301.

Neuropsychiatry in World War II

The Historical Unit of the U.S. Army Medical Service has recently published *Neuropsychiatry in World War II,* Vol. I, *Zone of Interior.* Outstanding men and women who participated in the events present this history, and the editors, Col. Albert J. Glass, MC, USA (Ret.) and Lt. Col. Robert J. Bernucci, MC, USA (Ret.) also contributed to the text.

The first volume records the administrative and professional frustrations, failures, and successes as they occurred in the Zone of Interior. The second volume, now in preparation, will be an account of neuropsychiatric problems in overseas theaters, both combat and noncombat.

During the early days of mobilization for World War II, it was believed that psychiatric disorders would occur only in so-called weaker individuals who were already predisposed to such illness. A major effort was made to exclude these individuals from military service by screening at the induction level. As the war progressed, it became clear that reliance on selection and elimination had failed to prevent the appearance of large numbers of psychiatric cases. Battle expe-

riences demonstrated that combat psychiatric breakdown could originate from normal or previously stable personnel, as well as from those of greater vulnerability.

The Army Medical Department was confronted with the task of dealing with an unprecedented incidence of psychiatric casualties for which there had been little preparation. The struggle to overcome these handicaps and the establishment of effective programs of prevention and treatment present an epic achievement in military medicine.

The gains made by military psychiatry in World War II had a direct bearing on the expansion of civilian psychiatry after the war. The exigencies of war fostered the concept and practice of the earliest possible treatment of emotional disorders, as near as possible to the site of origin. These wartime techniques were a stepping stone to the current nationwide movement for the establishment of community mental health centers.

The price of Volume I is $7.50, and it may be ordered from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

International Association for Suicide Prevention

The International Association for Suicide Prevention has among its goals the establishment of an organization in which individuals and societies of interested disciplines and professions from different countries can find a common forum for interchange of experience, literature, and information about suicide; wide dissemination of the fundamentals of suicide prevention among professionals and the lay public; to arrange for specialized training of selected persons in suicide prevention; and to encourage, assist, and carry out programs of research, especially those that can be pursued through international cooperation.

Officially founded in Vienna in 1965, the Association holds an International Congress every two years in a different country. The Third Congress was held in Basle, Switzerland in 1965 and the Fourth in Los Angeles, California in 1967. The Association publishes a newsletter *Vita,* and organizes special meetings in different countries to provide information on suicide to the public as well as to study national characteristics of the problem of suicide.

The Executive Board of the Association are Dr. Erwin Ringel, Vienna, Austria, president; Professor Erwin Stengel, Sheffield, England and Reverend Erik Bernspang, Tuma, Sweden, vice presidents; Dr. Norman L. Farberow, Los Angeles, California, general secretary; and Dr. Walter Poeldinger, Basle, Switzerland, treasurer.

Training Mental Health Workers

Metropolitan State College in Denver has started a two-year training program for mental health workers leading to the Associate of Applied Science degree.

The program calls for a broad educational base, specialized course work in biological and social sciences, and related field experience. Graduates are being trained to assume responsible treatment and rehabilitation functions in varied psychiatric treatment facilities and related agencies, and for further college work leading to a more advanced degree.

One-half of the students are to be chosen from under-privileged applicants. This source of untapped mental health manpower may also prove to be effective because there will be little social distance between the workers and some of the clients. There will be no decrease in standards or entrance requirements, and the mixture of disadvantaged and other students will allow a comparison both during the training and after graduation. If the project succeeds, it may be a major step in meeting manpower needs. Students needing financial help will be recruited by organizations representing the disadvantaged that have contacted the school seeking help for their members. Selection and determination of students needing financial assistance will be done by the Dean of Students under existing standards used for other students.

The Fort Logan Mental Health Center, which loaned staff to Metropolitan State College to start the program, has offered to hire the first 150 graduates. The Colorado Civil Service Commission is studying the creation of appropriate positions at realistic salaries, and the program has worked closely with the Colorado Department of Institutions which has also agreed to provide jobs.

The program will be evaluated by an assessment of agencies, their workers, and services both before and after the introduction of graduates and the impact of these new mental health workers on community attitudes.

Director of the program is Dr. Richard C. Ingraham.

SREB Program for Mental Health Workers

The Southern Regional Education Board has launched a program to foster common education and training of community mental health workers at junior and community colleges and to develop standard job descriptions among mental health agencies. Work in selected schools in five States in the SREB region will be emphasized; thus far, Maryland, Florida, and Alabama have been chosen.

During the first year, SREB will stimulate curriculum development. The second and third years will focus on assessment of education and training in several junior colleges in the region. During this time, SREB will promote collaboration between mental health agencies and participating colleges. The students will be on the job during the fourth year, and the final year will cover final evaluation and publication of the results of the project.

The program is designed to make community colleges and mental health agencies aware of future needs for new types of mental health workers. By working with both the training institutions and the agencies that will employ the trainees, the project hopes to train employees capable of working in a variety of mental health settings.

The Project Director is Mr. James Moncrief, formerly Dean of Jefferson State Junior College in Birmingham, Alabama. Address of the Southern Regional Education Board is 130 Sixth Street, N.W., Atlanta, Georgia 30313.

Continuing Education in Social Work

The need for social workers to keep abreast of changing theories and technology and for schools of social work to develop resources to make this possible has prompted the Council on Social Work Education

to begin to develop and set standards for continuing education in social work. Major emphasis in the plan will be to develop incentives and guidelines for the 63 schools of social work in the U.S. to develop programs of continuing education in mental health.

During the first year, the Council will appoint and convene an Advisory Committee to assist in planning and directing the project. The Council also expects to conduct surveys of current programs and needs, to visit schools of social work, to consult and assess continuing education efforts, and to prepare a bibliography of continuing education literature.

Later, the Council hopes to develop resources for holding conferences for faculty members of schools of social work having responsibility for developing or carrying out continuing education programs. It plans to develop materials for use in social work continuing education including teaching aids, special library resources, and to compile books of current theories and techniques to aid in the development of this relatively new concept of education in social work.

Project Director is Dr. Ruth E. Smalley, Council on Social Work Education, 345 E. 46th Street, New York, New York 10017.

Continuing Education in Wisconsin

The Wisconsin State Department of Health and Social Services has a project to expand continuing education for mental health personnel based on needs of a State mental health program. Plans call for extension of continuing education in three phases: Phase 1 involves establishment of a cooperative relationship between the Division of Mental Hygiene and the Extension Division of the University of Wisconsin. An advisory committee will be composed of the Director of Health and Social Services, Administrator of Mental Hygiene, Chancellor of the Extension Division, and a representative of the Governor's office. The committee will meet annually to review the program. Phase 2 involves the implementation of continuing education programs especially designed to meet the needs of specific target groups in State mental health programs. In the final phase, followup and methods to keep participants active in continuing education will be planned and initiated.

Training Mental Health Technicians

Mental health technicians—employees who work directly with patients in the treatment program—are being trained in a new two-year program at Sinclair Community College, Dayton, Ohio.

The Ohio Department of Mental Hygiene and Corrections cooperated in establishing the program and plans to establish a new job classification and positions for graduates to help solve the problem sometimes encountered by new, experimental programs which find that adequate pay is not always available for new professions.

The technicians will be trained to perform a variety of patient services, including admission interviews, testing procedures, home visits, and patient followup. The program is open to candidates with high school degrees up to age 60. Approximately 50 students will be selected for the first years, and course work will carry college credit acceptable for advanced degree work. During the second

year, students will receive training scholarships directly from the Ohio Department of Mental Hygiene and Corrections. The program will include formal classroom work and field work placement at the Dayton State Hospital and Dayton Children's Hospital.

Project Director is Dr. Martin Krauss, Sinclair Community College, Dayton, Ohio 45402.

Training in Community Organization

Three graduate schools of social work are collaborating in a program to train workers in the field of community organization at the Urban League of Washington, D.C. The schools are Howard University and Catholic University in Washington and the University of Maryland in Baltimore.

Through the League, first-year students are placed in community work and second-year students in social planning. A first-year student might be assigned to form a neighborhood development center. This would involve working with, and understanding, block clubs, learning community organization, and working with neighborhood and citywide organization projects. Second-year students might be responsible for developing a fair-housing program in a certain area for Negro service men, or studying the employment situation in the metropolitan area with particular reference to minority groups.

Upon completion of an assignment, students report back to the executive director of the League, the project director, and the full-time field instructor, who represents all three schools and the Urban League. Students frequently carry more than one assignment at a time. Typically, a student might be a committee member in an education program and also work in a volunteer office.

Responsibility and leadership are taught, in part, by having all students be chairmen or members of committees. Experiences are shared by having all students, both first and second year, attend group meetings. The program serves 10–12 students a year.

A report outlining the scope of the project has been published by the Urban League under the title "Field Instruction in Community Organization: A Recent Experiment."

Suicide in New Hampshire

The New Hampshire Department of Health and Welfare is engaged in a research project to identify high-risk suicide groups. In 1964, New Hampshire ranked seventh in the U.S. with respect to suicide. All suicides in the State in the past 10 years will be studied in an attempt to clarify the characteristics of the high-risk suicidal individual typical of a rural State. Age, sex, race, marital status, occupation, socioeconomic status, physical and mental health, place of residence at time of death, mode of death, and religion will be among the factors studied.

"Psychological autopsies" will be conducted for all suicides that occur in the State during the study, and all findings will be "computerized" for comprehensive analysis. Dr. Donald G. Niswander, Director of Psychiatric Education and Research of the New Hampshire Department of Health and Welfare is principal investigator.

Neighborhood Centers in South Bronx, New York

Three neighborhood centers,

components of the community mental health center for the South Bronx, New York, each serve about 6,700 persons annually. Given the size of the average family visiting the center, conservative estimates are that each center touches the lives of 26,000 people a year. The cost is less than $50,000 per center, or less than $2 per person.

The neighborhood centers are a unique combination of employment, training, social action, and service centers. The staff is made up of on-the-job-trainees and persons trained in the program supervised by professional staff. The trainees are previously unemployed residents of the area who have been or are part of special training projects for community mental health workers.

The three centers, each located in shopping areas near public transportation, handle varied and complex problems. People need help in dealing with agencies, with psychotic relatives, with bill collectors, with family planning or physical illness. Work is also being done with the welfare department and persons in legal trouble.

The centers rely heavily on group techniques. For example, housing complaints were so common that apartment tenants were organized to negotiate with the management. Working with the community mental health workers, tenant groups learned to assess housing code violations and to work with landlords.

The centers are one component of the Lincoln Hospital mental health service program which serves the South Bronx, and are part of the Department of Psychiatry of the Albert Einstein College of Medicine. The program also includes a rehabilitation program, consultation, training and education for public and voluntary agencies, a research department, and a training department.

Dimensions of Community Psychiatry

The Dimensions of Community Psychiatry is the latest in a series of reports published by the Group for the Advancement of Psychiatry. The report presents an overview of community psychiatry designed to help psychiatrists and their coworkers in other professions in planning and developing effective programs. It defines the psychiatrist's roles as he functions in a community psychiatry program as therapist, teacher, and/or investigator.

Examples of community approaches include psychiatric participation in the Peace Corps, psychiatric and social science contributions to community action programs such as those supported by the Office of Economic Opportunity and the Ford Foundation, and research and survey activities intended to identify environmental factors in mental illness through epidemiological studies.

The report also stresses the need for psychiatrists to have formal training as specialists in community psychiatry if the comprehensive community mental health centers are effectively to carry out a broad range of services and functions.

The GAP Committee on Preventive Psychiatry that formulated the report consists of Drs. Stephen Fleck (chairman), Gerald Caplan, Jules V. Coleman, Leonard J. Duhl, Albert J. Glass, Benjamin Jeffries, E. James Lieberman, Mary E. Mercer, Harris B. Peck, Marvin

E. Perkins, Harold M. Visotsky, and Stanley F. Yolles.

The 48-page report, which also contains an annotated bibliography, is available as GAP Report No. 69 for $1.00 from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, New York 10016.

Cost of Patient Care Programs in a Mental Hospital

Cost of Patient Care Programs in a Mental Hospital is a recent publication by William R. Foyle, C.P.A. It describes a study to develop a method to find and relate financial costs for operating mental hospitals to the patient care programs that occasion these costs. Previously, it was customary to obtain an overall average cost per patient day by dividing a hospital's total expense by total patient days. However, different types of patients require different kinds of treatment, and this means that cost per day varies with type of patient. Consequently, more sophisticated cost accounting is required, especially in view of the growth of insurance programs in the field of mental health.

This project developed an accounting and statistical system with sufficient refinement to delineate the variations in costs resulting from differences in patient population and treatment. It showed that unit costs increase as the "disturbance levels" of patients increase, that there is higher cost where patients are treated intensively in the early part of hospitalization, and that children's services are expensive—in fact, they were the costliest in the mental hospital studied.

The study also points out the importance of the use of computers for efficient and precise costing methods.

This 115-page booklet was published by the Bureau of Hospital Administration, University of Michigan, 220 E. Huron St., Ann Arbor, Michigan 48108.

95th Annual Forum of the National Conference on Social Welfare

The 95th Annual Forum of the National Conference on Social Welfare met in San Francisco on May 26–31, 1968. More than 5,000 participants attended the meetings, which revolved around the theme "An Action Platform for Human Welfare."

Among the major speakers were the Hon. Ramsey Clark, U.S. Attorney General; Hon. Wilbur J. Cohen, Secretary of the Department of Health, Education, and Welfare; Hon. Robert C. Wood, Under Secretary of the Department of Housing and Urban Development; Whitney M. Young, Jr., Executive Director of the National Urban League; Leo Perlis, Director of Community Service Activities of the AFL-CIO; Kent Mathewson, President of the Metropolitan Fund of Detroit; Hugh R. Jones, Attorney and Chairman of the New York State Board of Social Welfare; Mitchell I. Ginsberg, Human Resources Administrator of New York City; and Professors Frank Riessman of New York University and Arthur Pearl of the University of Oregon.

NCSW'S President, Wayne Vasey, professor in the School of Social Work at the University of Michigan, opened the Forum with his address on "The Welfare Crisis." The President-elect is Wilbur J. Cohen.

The annual Distinguished Service Awards were made to Mrs. DeLeslie Allen, active civic volunteer of Rochester, N.Y., and Dr. Kenneth B. Clark, psychologist and educator, of New York City.

124th Annual Meeting of the American Psychiatric Association

The American Psychiatric Association met in Boston on May 13–17, 1968. Dr. Lawrence C. Kolb, chairman of the department of psychiatry at Columbia University and director of the New York State Psychiatric Institute, succeeded Dr. Henry W. Brosin as president. Dr. Raymond W. Waggoner, chairman of the department of psychiatry at the University of Michigan and director of the Neuropsychiatric Institute at the University Hospital, is now president-elect. Vice-presidents are Drs. Paul Lemkau and Philip Reed; Dr. Robert S. Garber was re-elected secretary, and Dr. Hayden Donahue was elected treasurer. New members of the Council are Drs. Jack Lomas, Louis Jolyon West, and Duncan Whitehead.

A highlight of the meeting was the presentation of the APA's Distinguished Service Award to Senator Lister Hill. Several other awards were also made: Dr. Robert Coles received the Hofheimer Prize for his book, *Children of Crisis, A Study of Courage and Fear,* which describes his research on the emotional impact of racial discrimination and segregration on children of the South. Honorable mention in the Hofheimer competition was awarded to Dr. Joseph J. Schildkraut for his papers on biochemistry of psychiatric disorders and to Dr. Lee Robins for her book, *Deviant Children Grown Up, A Sociological and Psychiatric Study of Sociopathic Personality.*

Dr. Bernard Diamond, professor of criminology and law at the University of California at Berkeley, received the Isaac Ray Award, which honors those who have contributed to a better understanding between psychiatry and the law. The Agnes P. McGavin Award, honoring contributions to child psychiatry, went to Dr. George Gardner, director of the Judge Baker Guidance Center. Recipient of the Robert T. Morse Writers Award was Arthur Snider, science editor of the *Chicago Daily News.*

On the program were papers on traditional clinical topics and various therapies, social issues, hallucinatory drugs, riots, suicide, poverty, identity crises of Afro-Americans, psychiatric treatment and college admissions, college mental health, psychiatric and medical education, alcoholism, and psychiatrists in court.

An international seminar with speakers from Argentina, England, Hong Kong, Japan, Thailand, and Russia considered "Problems of Youth." A report on the exchange mission to the USSR was described. There were two joint sessions with the Royal Medico-Psychological Association of England, which examined "Law Reform and Homosexuality" and "The Impact of the National Health Service on Psychiatry."

55th Annual Meeting of the American Psychoanalytic Association

The American Psychoanalytic Association held its 55th annual meeting in Boston on May 10–13, 1968. The presidential address by Dr. Charles Brenner of New York City was on "Psychoanalysis and

Science." The incoming president is Dr. Samuel Ritvo, clinical professor of the Yale University Child Study Center and Department of Psychiatry, and the new president-elect is Dr. Royden Astley, Professor of Psychiatry and Director of the Pittsburgh Psychoanalytic Institute of the University of Pittsburgh School of Medicine.

The meeting included several interdisciplinary colloquia, an open meeting on "Psychoanalysis and Sex Education," and a joint meeting with the American Psychiatric Association on "Youth Unrest." Other meeting topics were "the hippie," community psychiatry, schizophrenia, psychosomatic conditions, concept of hysteria, and depression.

The Central Office of the Association is located at One East Fifty-seventh Street, New York, N.Y. 10022.

National Coordinating Council on Drug Abuse Education and Information

The Nation Coordinating Council of Drug Abuse Education and Information was officially created by a task force meeting held at the American Pharmaceutical Association in Washington, D.C. on May 20, 1968. The Council's functions are: to provide leadership and coordinate educational and informational efforts of organizations interested in the area of drug abuse; stimulate regional, State, and local involvement in drug abuse education by establishing interdisciplinary committees to respond to area needs; encourage research on drug abuse by identifying critical issues; evaluate and develop the role of professional and public information in the area of drug abuse; and evaluate drug abuse education programs and give visibility to those that are effective.

Temporary chairman is John Finlator, Associate Director of the U.S. Bureau of Narcotics and Dangerous Drugs, and temporary executive secretary is George Griffenhagen, Director of the Division of Communications, American Pharmaceutical Association.

The task force, an outgrowth of the FDA-APhA Drug Abuse Conference held in January 1968, has scheduled a future meeting at which permanent officers will be elected and a proposed charter presented for final adoption.

Study of World Psychologies

The Center for Study of World Psychologies was established by the City University of New York at Brooklyn College. It carries out interdisciplinary studies on psychology as a discipline in foreign countries as well as empirical studies on various aspects of the psychology of foreign man. The Center is building up library resources necessary for its research, including journals and books, collections of reprints from foreign authors, translations, and related materials. It also prepares abstracts of the Soviet literature in psychology and related disciplines, and provides Soviet and Japanese colleagues with reprints of American publications. Inquiries about the Center may be addressed to Dr. Ivan D. London, Center for World Psychologies, Brooklyn College, Brooklyn, New York 11210.

For Further Information

The *Mental Health Digest* contains condensations of original articles and other materials. The *Digest* must of necessity omit many important details, especially those concerned with methodology and discussion. Readers are therefore encouraged to consult the journal or other source in which the material first appeared or to write to the author for reprints. Addresses of authors whose articles appear in this issue are listed below. If an article has multiple authors, only the first author or the author from whom reprints may be obtained is given.

Dr. Gerald E. McClearn, Director, Institute of Behavioral Genetics and Department of Psychology, University of Colorado, Boulder, Colorado 80302.

Dr. D. D. Federman, Assistant Professor of Medicine, Harvard Medical School, Boston, Massachusetts 02115.

Dr. Mary S. Calderone, Executive Director, Sex Information and Education Council of the United States, 1855 Broadway, New York, New York 10023.

Rev. Morton T. Kelsey, Rector, Saint Luke's Episcopal Church, Monrovia, California 91016.

Dr. Stonewall B. Stickney, Division of Administration, Department of Mental Health, 750 Washington Avenue, Suite 200, Montgomery, Alabama 36104.

Dr. Marshall Shearer, Department of Psychiatry, University of Michigan Medical School, Ann Arbor, Michigan 48104.

Mr. Roger F. Aubrey, Department of Guidance and Counseling Service, University of Chicago Laboratory Schools, 5801 S. Ellis, Chicago, Illinois, 60631.

Dr. Donna M. Gelfand, Department of Psychology, University of Utah, Salt Lake City, Utah 84112.

Dr. Dorothy S. Dobbs, Behavioral and Clinical Studies Research Center, Saint Elizabeths Hospital, Washington, D.C. 20032.

Dr. Marvin B. Scott, San Francisco State College, 1600 Holloway Avenue, San Francisco, California 94132.

Dr. Shervert H. Frazier, Professor and Chairman, Department of Psychiatry, Baylor University College of Medicine, Houston, Texas 77025.

Dr. Melvin L. Selzer, Department of Psychiatry, University Hospital, Ann Arbor, Michigan 48104.

Dr. Christopher Bagley, Institute of Psychiatry, London, S.E.-5.

Mrs. Barbara B. Johnson, Bancroft Junior High School, San Leandro, California 94577.

Dr. H. D. Cohen, Department of Psychiatry, Albert Einstein College of Medicine, Yeshiva University, Bronx, New York 10461.

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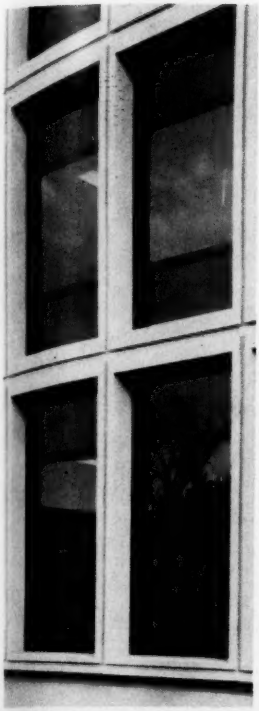

The Biological and Biochemical Research Division of the NIMH Mental Health Intramural Research Program has begun moving into new, expanded quarters. Five laboratories—Neurobiology, General and Comparative Biochemistry, Neurophysiology, Neurochemistry, and Cerebral Metabolism—will be relocated by late spring on three floors of a new five-story facility on the National Institutes of Health grounds.

The Division will share the new building with the National Institute of Neurological Diseases and Stroke and the NIMH Section on Technical Development which provides technological support to the intramural research programs of both NIMH and NINDS.

NIMH laboratories conduct research ranging from study of a single cell to the behavioral processes of entire nervous systems. Architects for the building were Smith, Hinchman and Grylls Associates, Inc., Detroit, Michigan. (NIMH photos by Calvin Nophlin.)

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